Series : 01/2009

AMREF Case Studies

Creating Systems for a Healthy Future in Africa

- Involving Communities in the Fight against Malaria
- Strengthening the Capacity of Traditional Health Practitioners to Respond to HIV/AIDS and TB
- The CASHE Model: An Innovative Way of Implementing Decentralised Water and Sanitation Services
- Building Community Capacity in HIV/AIDS Response: The Case of Maanisha Project

AMREF
Better Health for Africa

Co-ordinator: Dr Thomas N. Kibua

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AMREF CASE STUDIES is published by the Directorate of Health Policy and Systems Research. The main aim of the publication is to document evidence of success, challenges and lessons learnt from the organisation's projects. The case studies will serve as tools to inform health policy and practice in Africa.

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Editorial Team: Thomas Kibua, Josephat Nyagero, Betty Rabar, Kate Kiragu & Maureen Olyaro

Design & Layout: Bruce Kynes

Printed By:

FROM THE DIRECTOR'S DESK

This is the first generation of AMREF case studies. It is a first attempt aimed documenting evidence of success, challenges and lessons learnt arising fr AMREF's interventions in health development in Africa. We have embarked a journey to create tools to inform policy and practice by generating credi evidence aimed at providing solutions to community health policy and syste problems.

These case studies provide an empirical inquiry that investigates AMR attempts to generate rigorously vetted knowledge that will support intend changes to policy and practice. They chronicle AMREF's efforts in work closely with local populations to bridge the gap between health systems and communities. For example, the case study on traditional health practitioner South Africa illustrates how the capacity of the healers is harnessed and buil respond to and better manage patients with HIV/AIDS and TB. Their integrat is important and vital in preventing and mitigating the impact of these disea in the community. The use of mother co-ordinators in the fight against mal in Ethiopia underpins the importance of capacity building for human resour for health. That it is vital for communities to be the centre of health interventi is further evidenced in the implementation of water and sanitation programm in northern Uganda. The case study on fighting HIV/AIDS through commun based organisations in Kenya proves that working constructively with partn can be effective in bringing about changes in health care policy and serv delivery.

With these case studies AMREF is demonstrating its commitment to establish effective and sustainable community participation modules where communi have a decisive say in their health solutions. Since this is our maiden atter in documenting our interventions, the quality in terms of content, context a analysis is expected to be enhanced in subsequent editions.

Thomas N Kibua
Director, Health Policy and Systems Research

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INVOLVING COMMUNITIES IN THE FIGHT AGAINST MALARIA IN ETHIOPIA

By
Tilahun Nigatu, Berhane Haileselassie, Samuel Hailu and Dawit Seyum

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ABSTRACT

Malaria is still one of the leading causes of morbidity and mortality in developir countries. AMREF has been implementing a malaria prevention and contr programme in Afar region since 2005. The main activities include training healt care service providers, equipping health centres, training mother co-ordinator distributing insecticide treated nets and sensitizing local leaders on malar prevention and control.

As a result of this programme, the skills of over 200 health care service provide on diagnosis and treatment improved. There was a 34% increase in knowledg about transmission of malaria, 62.5% increase in ITN possession, and 48 increase in treatment seeking behaviour at community level. At present, abou 300 mother co-ordinators are in place at community level. There has also bee a significant decrease in epidemic occurrences of malaria. The programme ha demonstrated a reasonable and replicable model of malaria prevention an control by strengthening and linking the different segments of health system in pastoralist communities.

ACKNOWLEDGEMENTS

We would like to thank Dr. Thomas Kibua, AMREF's Director of Health Policy and Systems Research for his guidance during the compilation of this case study. We would also like to acknowledge the contributions of Dr. John Nduba, Dr. Alemayehu Seifu and Mr. Tadesse Fisseha who were involved in the design, implementation and monitoring of the Malaria Prevention and Control Programme in Afar.

We are grateful to CIDA, Band-Aid, Ferguson Trust, AMREF UK and AMREF Netherlands for the financial assistance in the implementation of the programme.

ABBREVIATIONS

ACT	Artemisinin Combined Therapy
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ARS	Afar Regional State
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CSA	Central Statistical Authority
DHS	Demographic Health Survey
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMM	Home-based Management of Malaria
ICRC	International Committee of the Red Cross
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
LLITN	Long Lasting Insecticide Treated Net
PCR	Polymerase Chain Reactions
PMPT	Participatory Malaria Prevention Tool
PNC	Post-natal Care
RDT	Rapid Diagnostic Tests
SP	Sulfadoxine Pyrimethamine
TFR	Total Fertility Rate
UK	United Kingdom
UNICEF	United Nations Children's Fund
USD	United States Dollar
WHO	World Health Organisation

1.1| INTRODUCTION

Ethiopia is Africa's second most populous country and one of the poorest. In 2006, it had an estimated population of 77 million of which about 45% lived in absolute poverty. Eighty-five per cent of the population reside in the rural areas and have limited access to basic health services. In 2005/06, the maternal mortality rate was estimated at 673 deaths per 100,000 live births, and infant and under-five mortality rates were 77 and 123 per 1000 live births, respectively. Most health facilities are located in urban areas. Majority of the residents within the eastern, western, south-western and south-eastern parts of the country remain marginalised and disadvantaged, with limited access to comprehensive health care services. [1]

Malaria is a major concern in the country since it is one of the leading causes of morbidity and mortality. Annual malaria mortality is about 70,000 and in a non-epidemic year, 5-6 million clinical malaria cases and over 600,000 confirmed cases are reported from health facilities. However, the actual number of malaria cases in the country is expected to be more than ten-fold of those captured through the routine public health surveillance system. [2]

Despite the current efforts to control malaria in Ethiopia, the situation has not improved mainly due to the increasing problems of parasite resistance to the relatively cheaper anti-malarial drugs, vector resistance to insecticides, low coverage of malaria preventive services, poor access to health care, rudimentary health service infrastructure, large population movements, and limited financial and human resources.

1. MOH. Health and Health-Related Indicators. Planning and Programming Department, Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2005/2006
2. Adhanom T, Deressa W, Witten KH, et al. Malaria. In: Berhane, Y., Haile-Mariam, D., Kloos, H. (Eds.), Epidemiology and Ecology of Health and Disease in Ethiopia. Shama Books, Addis Ababa, 2006, PP. 556–576

1.1.1 | AFAR REGIONAL STATE

The Afar Regional State (ARS) is located in the north-eastern part of the country. The region borders four national regional states i.e. in the north and north-west; Tigray region, in the west and south-west; Amhara region, in the south, Oromiya region and in the south-west; Somalia region. The ARS also shares international borders with Djibouti and Eritrea to the west and north-west, respectively. Administratively, the region is divided into five zones, which are further subdivided into 32 *woredas* and 404 *kebeles*. The total surface area of the region is estimated at 278,000 km^2.

According to official statistics, the region's population is about 1.5 million; of which 90% are pastoralists and 10% are agro-pastoralists. The rural population comprises about 92.2% of the total population. The major ethnic groups according to the Central Statistical Authority (1994) are the Afar (91.8%), Amhara (4.5%), Argobba (0.92%), Tigrayans (0.82%), Oromo (0.7%), Welayta (0.45%), and Hadiya (0.013%). Ninety-six per cent of the population are Muslim, 3.86% are Orthodox Christians, 0.43% are Protestants, 0.09% are Catholics, and other religions comprise 0.02% of the population.

The region has a high population growth rate – 2.2%, a TFR of 4.9 children per woman and a corresponding crude birth rate of 37.3 births per 1000 population (2005). The infant and under-five mortality rates of the region are estimated at 61 and 123 per 1000 live births, respectively. Children under five years of age constitute about 14% of the total population, and the number of pregnant women in the region per year is about 70,000.

Afar is predominantly (90.8%) spoken in the region and is the working language of the state. Other languages with a significant number of speakers include Amharic (6.68%), Tigrigna (0.74%), Oromo (0.68%), Argobba (0.4%) and Wolaitigna (0.26%).[3]

The overall health status of the Afar population is poor, with women and children particularly vulnerable to poor health. Maternal mortality (720/100,000) and under-five child mortality (229/1000) are double the national average. Women have a particularly low status, face heavy workloads, are exposed to severe risks during pregnancy and delivery, and are unable to control safe sexual practices with partners, thus increasing their vulnerability to HIV/AIDS. All these undermine efforts to improve reproductive health. Traditional practices, including FGM (94.5% in Afar) pose human rights and public health concerns. Low uptake of contraception and early pregnancy affect maternal health, leading to obstructed

3. *The 1994 census was delayed in the Afar region until 22 July 1996*

labour, vesico-vaginal fistulas and foetal death. Currently there are low utilisation rates of reproductive health services, ANC and PNC (7.3%, 16.1% and 1.2% respectively). Less than 10% of births are attended by skilled personnel, and Afar is not equipped to provide emergency care.

The vital statistics of Afar region, Ethiopia in 2006/7 are shown in Table 1.1.

Table 1.1: Vital statistics of Afar region

Vital statistics indicator	Indicator value
Crude birth rate per 1000	37.3
Rate of natural increase	2.20
Total fertility rate	4.9
Infant mortality rate per 1000	61
Child mortality rate per 1000	66
Under-five mortality rate per 1000	123
Male life expectancy	56.9
Female life expectancy	50.8

Source: Health and Health-related Indicators in Ethiopia 2005/06

According to the 2005/06 Regional Health Bureau data, there are two hospitals, 14 health centres, 44 health stations and 83 health posts in the region. These are run by the government. In addition, there are 10 small and medium level privately-owned clinics and only one hospital which is operated by a non-governmental organisation. There is no health training school in the region. In 2005/06, there were only 10 physicians and 10 health officers working in the area. The health professional to population ratio is very low with one physician serving 138,900 people (WHO standard is 1:10,000), and one nurse serving 5,426 people (WHO standard is 1:5000).

Malaria transmission in the region is generally unstable, with perennial transmission in areas along the Awash River Valley. In 2006/07, there were a total of 289,852 cases of all types of malaria. There were 20,323 under-fives and 1605 pregnant women with malaria who were attended to in the outpatient department the same year. In addition, there were 625 under-fives and 64 pregnant mothers with severe malaria admitted in the region .[4]

4 Health and Health-related indicators Ethiopia 1999 EC

In the Demographic Health Survey estimates for Afar region, 21% of household owned at least one type of mosquito net, and only 6% had more than one net. About 6% of households reported owning at least one insecticide-treated mosquito net (ITN). According to the survey carried out in 2005, about 14% of children less than five years of age slept under a net the preceding night and only 3% of the children slept under an ITN. About 12% of all women (15-49 years) and 13.3% of pregnant women slept under a net the preceding night. Similarly, 3.8% of all women aged 15-49 years and 6% of pregnant women slept under an ITN. The 2005 Ethiopian DHS also showed that among 10,000 children less than 5 years, 18.7% had experienced fever within the previous two weeks (17% in Afar). While fever is a common symptom of malaria onset, 6.6% of those surveyed had received an anti-malarial drug within 48 hours.

1.2 | THE NATIONAL PROGRAMME

Malaria remains the leading cause of morbidity and mortality in Ethiopia. Combating HIV/AIDS, malaria and other diseases is among the eight Millennium Development Goals. The achievement of this goal will also contribute to reduction in maternal and child mortality.[5]

The annual report (2005/06) of the Federal Ministry of Health (FMOH) in Ethiopia states that malaria accounts for 17.8% of outpatient consultations, 14.1% of admissions and 21.8% of inpatient deaths. The disease mainly affects those living in rural areas due to the existence of abundant mosquito breeding sites, poor housing conditions and inability to afford preventive measures, coupled with low awareness of the preventive methods.

The Ethiopian Health Policy indicates that malaria is second in the list of priority issues. It is also part of the policy strategies in the health policy. As common communicable diseases and malnutrition are the major health problems accounting for about 75% of the problems, the policy has placed emphasis on interventions that reduce the impacts of these common health problems[6]. The Health Sector Development Programme III of Ethiopia has also considered the prevention and control of malaria as an integrated programme within the health system. The Health Service Extension Programme has also included malaria prevention and control among its 16 packages.[7]

Ethiopia's major malaria transmission season occurs between September and December following the June-August heavy rainfall, while the second peak, though less pronounced and mainly limited to the eastern and south-eastern parts of the country, occurs during April and May, following the short rains. However, perennial transmission occurs in lowland areas with permanent water bodies such as Awash and Genale, and in some peripheral areas of the western and south-western parts of the country.

The epidemiological pattern of malaria transmission in Ethiopia is generally seasonal and highly unstable due to variations in topography and rainfall patterns. Hence, large-scale epidemics frequently occur particularly at higher altitudes. Marked variations in the level of transmission from place to place or seasonal fluctuations in the number of cases are the main features of malaria transmission in Ethiopia. As a result of the short peak transmission and the relatively long duration of low transmission during the dry season, people are highly vulnerable to malaria due to lack of acquired immunity that comes with frequent exposure to malaria infections, resulting in the occurrence of frequent epidemics.

5. *UN Millennium Development Goals available at www.un.org/millenniumgoals accessed on July 16, 2008*
6. *Health Policy of Transitional Government of Ethiopia, 1993*
7. *Health sector development plan of Ethiopia 2005-2010, Federal Ministry of Health Ethiopia*

The main technical elements of the malaria prevention and control programm comprise early diagnosis and treatment, vector control and epidemic preventio and control. The supporting strategies include human resource developmen operations research, information, education and communication, an programme monitoring and evaluation.

In order to reduce the overall burden of malaria by 50% in 2010, the nationa malaria prevention and control programme has been working to achieve th following:

(a) 100% access to effective and affordable treatment for malaria: this aims t increase the proportion of fever-related cases receiving treatment at healt facilities (35.6% in 2005). It also includes training of health workers to ensure a increase in proportion of health facilities with at least one health worker traine on malaria diagnosis and treatment guidelines (53.6% in 2005). The programm also distributes diagnosis and treatment guidelines to raise the proportio of health facilities that receive the national malaria diagnosis and treatmer guidelines (53.6% in 2005).

(b) 100% coverage of all households with ITNs, with at least two ITNs pe household: this method aims at vector control through the use of Long Lastin Insecticide Treated Nets (LLITNs). An estimated 15.5 million LLITNs had bee distributed to users by 2005. In the same period, 5,108,168 nets had bee procured for future distribution. By the end of 2005, a further 700,000 nets ha been secured with negotiation from partners. The total coverage was 88%, wit at least two ITNs per household.

(c) Early diagnosis through the use of rapid diagnostic tests: for the diagnos of suspected malaria cases in areas where laboratory facilities are limited, rapi diagnostic tests are used.

(d) Early detection and management of 80% of the malaria epidemics withi two weeks from onset: this method is intended to increase the proportion epidemics detected within two weeks of onset (31% in 2005). This follows fro an increment in percentage of districts with adequate epidemic preparedne plan on average (47.8% in 2005). This increment means training more healt workers (6357 trained at the end of 2005) on the national epidemic preventio and control guidelines and distributing the guidelines to health facilities (256 guidelines distributed at the end of 2005). It also requires instituting malar epidemic monitoring charts at health facilities (2213 health facilities were usin the guidelines by the end of 2005).

(e) Raising awareness of the public on the disease: several methods have been designed to enhance the awareness of the public on malaria transmission, symptoms, prevention and treatment. Effective media coverage and malaria week are among the key activities used in raising the awareness of the community about the disease. Basic malaria education has been incorporated in the training of the various categories of community health workers.

(f) Anti-malaria drug resistance monitoring: in addition to the operational research on anti-malarial drug resistance, a monitoring activity for the three first-line drugs is being carried out in 17 hospitals in the country. This is aimed at detecting resistance and informing the policy on anti-malarial drugs in the country.

1.3 | THE MALARIA PREVENTION AND CONTROL PROGRAMME IN AFAR

Malaria control strategies are based on the biological basis of malaria transmission. Reducing breeding sites is one of the strategies. Malaria transmission can be interrupted by reducing mosquito survival to less than the duration of sporogony. Controlling transmission is more effective than merely reducing the mosquito density and indoor residual spraying is far superior to larvicide application or space spraying to attack the mosquito populations.

It is widely understood that malaria control is too complex to be addressed by a single approach. A multi-pronged strategy tailored to the prevailing ecological and epidemiological conditions is likely to be more successful. Three control strategies in place include mortality control, transmission control and eradication.

The objectives of the intervention in Afar were to:

- Increase the use of mosquito nets by pregnant women and young children
- Improve the quality of testing being carried out to diagnose malaria
- Develop systems that allow people to treat malaria with effective drugs in the home
- Educate communities about how to control the spread of malaria
- Strengthen AMREF's partnerships in Afar and to expand the programme to cover more areas of the district.

Expected outputs of the programme include:

- Reduced morbidity and mortality among young children and pregnant women
- Reduced occurrences of fever in children under five years
- Reduced occurrence of malaria among pregnant women
- Community knowledgeable on malaria transmission and prevention
- Increased capacity of target woredas to manage malaria epidemics.

1.3.1 | ACTIVITIES

AMREF's Malaria Prevention and Control Programme in Afar region focuses on improving case management at health facility level, increasing ITN coverage and utilisation at family level, and enhancing behaviour and social change in support of malaria prevention and control. The operational components are discussed.

Strengthening the capacity of health workers

The national anti-malarial drug policy replaced SP with artemether-lumefantrine (AL) as a first-line treatment for falciparum malaria, thus when AMREF started its malaria prevention and control programme in Afar, the MOH and the GFATM had provided adequate supply of AL to health facilities in the region. However, there was an acute shortage of health manpower with adequate skills. Recognising the need for training of health workers on malaria diagnosis and treatment in Ethiopia, particularly in Afar region, AMREF carried out a series of training workshops for all categories of health professionals drawn from all over the region on the correct use of the new anti-malarial. A total of 202 health workers from six different professional categories were trained on case management, each for about five days at the capital of the region, Semera, in June 2006. The health workers comprised 10 physicians and health officers, 27 pharmacy technicians, 35 senior nurses, 80 junior nurses, eight laboratory technicians and 42 frontline health workers.

Enhancing health facilities' capacity in diagnosis and treatment

AMREF in Ethiopia provided 27 binocular microscopes and adjuvant reagents worth US$ 44,000 to Afar Region Health Bureau for distribution to health centres and hospitals in the region. The existence of *P. falciparum* and *P. vivax*, all with different regimens, and the high cost of artemether-lumefantrine heightened the need to improve the quality of laboratory diagnosis for malaria.

In order to improve diagnosis and management of malaria cases in areas where laboratory-based diagnostic service are not available, rapid diagnostic tests (RDTs) were introduced to complement clinical diagnosis. As a result, RDTs for malaria have offered a potentially simpler solution to malaria diagnosis in settings where microscopic facilities are unavailable.

Home-based management of malaria

Home-based management of malaria (HMM) has recently been promoted as a major strategy in the improvement of prompt access to effective anti-malarial treatment particularly in sub-Saharan Africa. In Ethiopia, access to health care facilities mostly by the rural hard-to-reach population is limited

due to geographical, economical and socio-cultural barriers. HMM is a simple and practical approach for improving the management of children with fever/malaria at community and household level.

Community-based malaria control interventions using community health workers (CHWs) and mother co-ordinators was adopted in the country in the 1990s to improve the population's access to early diagnosis and treatment, resulting in the decentralisation of facility-based malaria treatment at the village level. Consequently, malaria control strategies are closer to the community, and most first-line anti-malarial treatments are provided by CHWs. AMREF implemented HMM through mother co-ordinators and community health workers who train caregivers and refer cases early to the health facility.

Participatory communication tools and picture-based messages

To ensure participatory communication in malaria control, AMREF developed and tested a Participatory Malaria Prevention and Treatment (PMPT) toolkit in 2006 in collaboration with the Afar Regional State Health Bureau, *woreda* health offices and UNICEF.

The major topics in the toolkit focus on signs and symptoms of malaria, appropriateness of early diagnosis and prompt treatment with effective anti-malarial drugs (artemether-lumefantrine) particularly among the under-fives and pregnant women, traditional practices, the role of the mosquito in the transmission of malaria and preventive measures such as proper utilisation of ITNs/LLITNs, indoor residual spraying, and environmental management using simple pictures that can be easily understood by individuals at community level with little or no education.

The toolkit was developed and tested after a thorough analysis of the cultural and traditional beliefs towards malaria prevention and treatment, based on the findings of the baseline survey and focus group discussions of the studies carried out in 2005 and 2006, respectively.

Recruitment and training of mother co-ordinators

This included training of trainers for 24 participants selected from *woreda* health offices, peripheral health facilities, *woreda* administration offices, malaria control experts, AMREF staff, and partner NGOs such as International Committee of the Red Cross (ICRC) and UNICEF in Zone 3 of the Afar region. The trainers in turn

are supposed to conduct *woreda*-based training for mother co-ordinators. As a result, about 300 mother co-ordinators were trained in 2007 in five of the six districts in Zone 3.

The training of mother co-ordinators was conducted in two phases. The initial training took five days and topics covered included signs and symptoms of malaria, its mode of transmission, preventive measures with particular emphasis on ITNs/LLITNs utilisation, and the importance of early diagnosis and prompt treatment with effective anti-malarial drugs. The mother co-ordinators were then deployed to educate the community on the different aspects of malaria prevention and control. Each one was expected to educate 30 households. Thus a total of 9,000 households (about 45,000 persons) were reached with appropriate information.

Training local leaders

In pastoralist communities, traditional structures are more influential than the formally organised structures. Recognising this fact, AMREF in Ethiopia trained local leaders of the Afar pastoralist communities in malaria transmission and prevention strategies so that they could facilitate the interventions of the Foundation with regard to malaria. These local leaders were also involved in the recruitment of mother co-ordinators and distribution of ITNs. They generally facilitated the link between the health system and households.

ITN distribution

Door-to-door LLITN distribution was conducted to raise the ITN coverage in line with the increase in knowledge, attitude and practices of the community on malaria. AMREF co-ordinated the distribution of about 145,000 LLITNs in Zone 3 of Afar region. The educational efforts in the utilisation of ITNs have focused on pregnant mothers and children under five years, since they are the most vulnerable segments of the population.

1.3.2 | RESULTS OF THE INTERVENTION

Before the start of the programme, a baseline assessment on knowledge attitude and practices of the community on malaria prevention and control was conducted.

Three operational research questions were set following the start of the programme:

- What are the test performances of RDTs compared to blood microscopy and Polymerase Chain Reactions (PCR) under field conditions in Afar?
- Can RDTs be handled by community health workers including the mother co-ordinators?
- How effective is the traditional cooling system *(beha)* in keeping the RDT kits at the recommended temperature (4-30^{0}C) in Afar?

This baseline study established the status of the indicators of the programme' success in Afar region.

As a result of the programme's activities, the proportion of community member who correctly identified the transmission methods of malaria had increased from 27.4% in 2005 to 61.5% in 2007. This means there was a 34.1% increase i knowledge about the transmission of malaria among the community in th given programme period. In addition, knowledge of communities on the sign and symptoms of malaria had increased from 84.3% in 2005 to 88.4% in 200 indicating an increase of 4.1%. This is because of the initial high baseline rate o knowledge.

On the other hand, knowledge on the prevention methods of malaria before an at the end of intervention remained at around 67.5%. This knowledge is simp whether the community members know some of the prevention methods o malaria. However, comprehensive knowledge about the prevention and contr of malaria is still low in the target communities of Afar region.

As a result of the door-to-door distribution of LLITNs, the coverage of at least on ITN in the target communities had increased from 7.5% in 2005 to 70.2% in 200 This has demonstrated the effectiveness of distributing LLITNs in conjunctio with utilisation-focused health education. However, the need for replaceme of torn and worn out ITNs is imminent.

The proportion of pregnant mothers who slept under ITNs the previous nig in Afar community had increased from 27% in 2005 to 86.5% in 2007. Similar the proportion of children under five years who slept under ITNs the previo

night had increased from 17% in 2005 to 84% at the end of 2007. Besides, the increase in the ownership and the utilisation of ITNs can be attributed to the change in knowledge about the transmission methods of malaria among the target communities.

Treatment seeking behaviour for fever among the community had increased to 48%. Of those who sought treatment for fever, 16.4% did so within 24 hours of onset of fever. However, only 14.3% of under-five children with fever sought treatment within 24 hours of onset. This indicated that there were improvements in treatment seeking behaviour, but there were other limiting factors like long distances to access treatment services. During the years of AMREF's presence in the area, the epidemic occurrences in malaria declined significantly.

1.3.3 | RELATED ISSUES

Based on the experience of the Malaria Prevention and Control Programme in Afar, the sustainability, multiplier effects, attributability and cost-effectiveness issues are as follows.

Sustainability and multiplier effects

The major activities in the programme were training and deployment of mother co-ordinators, strengthening the health systems through training of health workers and support of health facilities, increasing ownership and utilisation of ITNs, and appropriate case management at the community and facility level. To address the concern of sustainability, the programme linked the mother co-ordinators and local leaders (trained and supporting the programmes) to the Health Extension Workers (HEWs). This was achieved by establishing a working team of HEWs, mother co-ordinators and local leaders at community level.

It is also assumed that the health system, the capacity of which was strengthened by this programme, would be able to take over and effectively handle the community-based malaria prevention scheme. For the communities in Afar formal health systems transformed, strengthened, and included communities. District health plans integrated malaria prevention and control activities within the other activities.

The multiplier effects of using mother co-ordinators were designed systematically. That is, one mother co-ordinator was selected among 30 mothers based on relevant and locally applicable criteria. A mother co-ordinator was responsible for educating up to 30 mothers based on the distances between households. The health system has recognised the mother co-ordinators who are currently reporting to the nearby community health worker.

The Epidemic Prevention, Preparedness and Response Committee with a representative from the community was established in Afar Zone. The committee is currently working on early warning, preparedness and management of common epidemics and disasters like flooding. These initiatives have been adopted by NGOs and UNICEF to develop a comprehensive disaster prevention plan.

Though the sustainability of the effects of the intervention will depend on the continuous efforts of the health system in using the availed links with the community, AMREF in Ethiopia has laid the foundation. During the mid-term evaluation study conducted in December 2007, it was evident that the knowledge and practices embedded in the community-owned social capital was still operational.

Attributing results to intervention

At the beginning of the malaria programme, AMREF conducted a baseline study in six districts of Afar region zone 3. This baseline set the benchmarks for the monitoring and evaluation of the programme. The malaria programme intervention was in place in all the six districts of the zone. The activities were monitored every three months and the final evaluation was conducted in all the six districts.

The evaluation design used was the non-randomised pre-intervention and post-intervention comparison of the basic indicators. This described the difference between the initial and final measures of the indicators. The limitation in using this design is that it only provides the status of the indicators at the beginning and end of a programme. The changes may not be completely attributed to the intervention put in place.

However, the changes in the indicators in the Afar situation can mostly be attributed to the malaria programme implemented by AMREF since it was the sole community-based intervention in the area. Other stakeholders were mainly focused on HIV/AIDS and other reproductive health issues.

It is evident that there are cross-cutting interventions like the media that disseminates information on malaria prevention and control. There are also movements of the Afari people that can expose them to different types of information on malaria.

Table 1.2 : Comparison of baseline and end-line indicators of the programme

Variable	Baseline	End-line	Change
Proportion of community members who correctly identified the transmission methods of malaria	27.4%	61.5%	34.1%
Knowledge of communities on the signs and symptoms of malaria	84.3%	88.4%	4.1%
Knowledge of the prevention methods of malaria	67.5%	67.5%	0%
The coverage of at least one ITN in the target communities	7.5%	70.2%	52.7%

Variable	Baseline	End-line	Change
The proportion of pregnant mothers who slept under an ITN the previous night	27%	86.5%	59.5%
The proportion of under-five children who slept under an ITN the previous night	17%	84%	67%

Though the whole change cannot be attributed to the Malaria Prevention and Control Programme, there is no doubt it has contributed to the majority of the changes in the basic indicators.

Cost-effectiveness of the programme

Besides the direct comparison of the cost incurred in the implementation of this programme and the actual outcomes, there are several proxy indicators that indicate the cost effectiveness of the programme. Above all malaria prevention and control activities in Afar region, where pastoralists are dominant and remained under-served by the formal sector (both service and information) is an issue of equity. Moreover, malaria prevention is not all about disease prevention and curing; the benefits are above and beyond the individual. For instance, a community-based cross-sectional study of 2195 households in the nearby zone of Oromia, East Shewa (Adami Tulu district) in 2003 indicated that among 12,225 surveyed individuals, 1748 (14.3%) reported perceived malaria during the preceding two weeks. Seventy-seven per cent (77%) sought some form of treatment and 70% had recovered at the time of interview. The average treatment cost per patient at private clinics was Birr 24.00 ($2.76) and Birr 12.5 ($1.44) at public facilities. The average estimated direct cost of malaria per patient was Birr 14.00 ($1.60); the average indirect cost, Birr 35.26 ($4.08). Only 5% of all households reported any preventive expenditure in the preceding month, with a mean of Birr 0.76 ($0.09). Thus, externalities (economic, social and environmental) are visible in such interventions.

The use of community-owned social capital

Mother co-ordinators are volunteers who are motivated to work without being paid. Local technologies like PMPT and picture-based messages were designed locally. The traditional system was used to reach the community. All these indicate that the most cost-effective methods were used rather than the formal and costly methods. Community members easily detect fever using community embedded capacity and refer children and women to health facilities, which implies no cost for initial diagnosis.

Working within the existing structure and infrastructure

The programme activities were aligned to the national malaria prevention and control strategy which enabled the utilisation of facilities and human resource established by the government of Ethiopia. ITNs were also accessed from UNICEF for distribution.

PMPT tools

The cost of PMPT tools reproduction is as easy as writing on a piece of paper and laminating it. Reproduction and distribution of PMPT tools can be handled by anyone. The tools are easily portable, usable and replicable. They are also flexible for adoption and community needs and changes can be incorporated as needs arise with minimal support from specialists and professionals. Once a PMPT tool is produced it can be utilised for a number of years.

Capital goods

At the end of the programme capital goods such as computers, vehicles and microscopes with a current book value of USD 72,720 will continue to serve the community.

Beneficiary/dollar ratio

The programme results are obtained with an investment of USD 4.2 per beneficiary. This is less than an average health expenditure of a family's single hospital visit. The cost is equivalent to an earning of three healthy days, assuming that an Ethiopian unskilled labourer earns USD 1.5 per day (Yared, 2006).[8] Conversely, given the prevalence of 13.7% (final evaluation figure reported for two weeks, the lowest figure after intervention), within the beneficiary of 210,000, it is estimated that 28,770 individuals suffer from fever every two weeks. If the patients are sick for only one day, and are not engaged in any economic activity, the population loses USD 949,410 within one year inclusive of treatment cost. As indicated above[9] the average estimated direct cost of malaria per patient was Birr 14.00 ($1.60); the average indirect cost was Birr 35.26 ($4.08). Thus, the programme investment per beneficiary can be safely described as cost effective. Harsh environmental conditions, the need to travel long distances to reach communities, and mobility of the community during the implementation of the programme accounted for a lot of the challenges.

8. *Yared Birhanu (2006): Determinants of Daily Earnings in the Plantation Sector, MA Thesis, Department of Development Studies Addis Ababa University.*
9. *See Wakgari et.al (2008)*

1.3.4 | LESSONS LEARNED

The following lessons were learned from this intervention.

The need for concurrent actions on health workers and health facilities

Building the capacity of human resource for health cannot result in change i the health facilities' capacity is not enabled to exercise the built capacity. In thi programme, the effectiveness of concurrent actions on health workers an health facilities is demonstrated.

Linking mother co-ordinators with the health system

The malaria programme in Afar region has implemented its community-base interventions using mother co-ordinators selected by the community, requirin the need to link them to the health facilities in the areas. The critical issue wit respect to sustaining the services of community-based mother co-ordinators that they provide the services without payment, making it difficult to maintai their motivation. In this regard, there is an evident need to link the mother co ordinators with the HEWs assigned in their villages.

Involving local community leaders in health intervention

In pastoralist communities there are local traditional leadership systems tha are deep-rooted and respected by the majority of community members. Th programme recognised the role of the traditional leadership system and utilise it to reach and influence the behaviour of the community at large. Thus, th greatest lesson learnt is that interventions can be facilitated if the local structu is recognised and well utilised.

Involving the local health system in programme activitie

The district, zonal and regional structures play a crucial role in formulation an implementation of policies. The most effective strategy in influencing poli and practice is to involve policy makers during the early stages of programm implementation. The Malaria Prevention and Control Programme in Af involved the district health systems in all critical activities of the programme.

Door-to-door distribution of insecticide treated nets

The most reliable method to ensure a service reaches and is used by household to provide the service directly to the target community and educate them on th utilisation. The malaria programme had implemented door-to-door distributi of LLITNs with concurrent education on its utilisation. This has contributed a l in narrowing the difference between possession and utilisation.

Utilisation of locally applicable technology for intervention

Modern and electronic materials are hardly used in nomadic communities. The programme thus developed locally applicable and culturally-sensitive methods. AMREF designed user- and consumer-friendly PMPT and complementing picture-based messages. In addition, counting of gravel was used to report activities by mother co-ordinators.

1.3.5 | RECOMMENDATIONS

Based on the experiences in the implementation of the Malaria Prevention and Control Programme in Afar, the following recommendations were made:

1. Given the high turnover of trained staff in Afar region, there is continuous need to provide in-service training for the new health workers. In addition, there should be a system in place to retain the trained staff.

2. Since communities are the centre of a health system, the district health offices should utilise the community structures to narrow the gap between the communities and the health system. It would also be helpful to create networks and organise these structures for successful implementation.

3. To effectively reach the community with user-friendly services the mother co-ordinators should have a greater role. Hence there is need to integrate these co-ordinators' activities with those of the rest of the health system to ensure appropriate follow up.

Generally, this programme has demonstrated a reasonable and replicable model of malaria prevention and control by strengthening and linking the different segments of a health system in pastoralist communities. Enhancing the capacities of health workers and health infrastructure at facility level, improving the capacity of the community to own their health, and creating a linkage between communities and the health facilities by community accepted agents were the key components.

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2

STRENGTHENING THE CAPACITY OF TRADITIONAL HEALTH PRACTITIONERS TO RESPOND TO HIV/AIDS AND TB IN KWAZULU NATAL, SOUTH AFRICA

By

Melusi Ndhlalambi

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ABSTRACT

South Africa is currently experiencing explosive twin pandemics of HIV/AIDS and tuberculosis (TB), with over 16% of the population infected with HIV/AIDS. Two-thirds of those with HIV/AIDS also suffer from TB due to their weakened immune systems. AMREF has been implementing a traditional health practitioners project whose aim is to contribute towards effective and efficient management and integration of HIV/AIDS, STIs and TB services by traditional healers in Umkhanyakude district, KwaZulu Natal, South Africa.

This paper presents the experiences, impact and lessons of the innovative approach of working with traditional healers in HIV and TB prevention and control programmes, especially at the primary health care level.

ACKNOWLEDGEMENTS

I would like to thank the following: Tryphina Ngwenya, (former AMREF project manager) for the great work she did in documenting this model, implementing its replication in Umkhanyakude and reviewing the paper; Dr Thomas Kibua, AMREF's Director for Health Policy and Systems Research, for providing guidance and reviewing this paper, and Betty Rabar for editing the document.

I am grateful to the EU, and AMREF in Canada who provided the funds that were utilised during the project implementation.

ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
AMREF	African Medical and Research Foundation
ART	Antiretroviral Therapy
C-IMCI	Community Integrated Management of Childhood Illnesses
DIME	Design, Implementation, Monitoring and Evaluation
DOTS	Directly Observed Treatment Short-course
HBC	Home Based Care
HIV	Human Immuno Deficiency Virus
KZN	KwaZulu Natal
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
Pop.	Population
PSC	Project Steering Committee
SAMA	South African Medical Association
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
THP	Traditional Health Practitioner
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

2.1 | BACKGROUND AND PROBLEM STATEMENT

Everyday, over 6800 people become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services. The HIV pandemic remains the most serious of infectious disease challenges to public health. Sub-Saharan Africa is the most seriously affected region. The estimated number of deaths due to AIDS in 2007 was 2.1 million [1.9–2.4 million] worldwide of which 76% occurred in sub-Saharan Africa.

As the HIV/AIDS epidemic grinds on relentlessly in sub-Saharan Africa, South Africa is experiencing twin pandemics of HIV/AIDS and tuberculosis (TB). KwaZulu Natal has an estimated 60% co-infection rate of HIV and TB. According to the National Department of Health[1] , KwaZulu Natal's HIV prevalence rate is 36.2% (95% CI: 33.4-39.0), the highest provincial rate compared to national figures estimated at 24.5% (95% CI: 23.4-25.6). In recent years, there has been an alarming resurgence of TB cases in South Africa, increasing from 92,380 in 1996 to 215,154 in 2003.[2] Incidences of TB in KwaZulu Natal is now estimated at 591/100,000, much higher than the national average of 556/100,000 (Statistics SA 2005). Factors contributing to this include a low demand for voluntary counselling and testing (VCT), late reporting to formal health facilities and an increasing trend of non-adherence to treatment.

HIV and TB have added an increasing demand to the health system. According to the KwaZulu Natal annual report (2007), the ability of the province's health system to cope with demand is compounded by high (17%) nurse vacancy rate, high attrition rates for both doctors and nurses (60% and 13%, respectively), an average recruitment rate of 72% for nurses and doctors and an unsustainable 50% nurse absenteeism. The burden posed by both diseases is further compounded by unequal distribution of resources, inability to access health facilities (long distances travelled for over two hours) and shortage of health care workers .[3] According to the KwaZulu Natal annual report (2007) the average provincial nurse workload ratio is high (1:8333) and even higher for doctor:patient (1:155000). shows that for every 1000 people in a rural area such as Umkhanyakude, there are 84 nurses.

1. *National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa: 2000.*
2. *South African TB Crisis Plan (2006)*
3. *World Economic Forum White Paper (2006). From Funding to Action: Strengthening Health Systems in Africa.*

AMREF Case Studies 2009

Table 2.1: Ratio of people per health professional

Input	2003/04 Actual	2004/05 Actual	2005/06 Actual	2006/07 Actual
Medical Officers per 1000 people	10.08	11.63	14	16
Medical Officer per 1000 people in rural district	6.53	9.77	9	10.5
Nurse per 1000 people	96.33	96.52	101	103
Nurses per 1000 people in rural districts	75.60	101.16	84	88
Pharmacists per 1000 rural districts	2.17	2.5	10	15
Pharmacists per 1000 people in rural districts	0.81	1.65	5	8

Source: KwaZulu Natal Department of Health Annual Report, page 109. (2007)

As noted in Table 2.1, the average number of nurses per rural district is 88 per 1000 people. This high patient-nurse ratio makes the role of traditional health practitioners (THPs) key in providing health services. It is estimated that there are close to 200,000 traditional practitioners in South Africa. Table 2.2 shows that KwaZulu Natal (KZN) has the third largest population of THPs (25,430) in South Africa. Despite the high number of THPs, very few (2,719) have received any form of training, a gap that AMREF sought to address through the THP initiative.

Table 2.2: Number of THPs in South Africa by province

Province	TOTAL
Eastern Cape	10,780
Free State	22,645
Gauteng	61,465
KwaZulu Natal	25,430
Limpopo	7,366
Mpumalanga	57,524
North West	5,935
Northern Cape	2,221
Western Cape	2,600
TOTAL	**185,477**

Source: Indigenous Health Care Systems, University of KwaZulu-Natal

AMREF Case Studies 2009

Table 2.3 : Number of THPs per District in KZN

INDICATOR	Ugu	Ethekwini	Ilembe	Uthungulu	Umkhanyakude	Umzinyathi	Amajuba	Uthukela	Umgungu	Sisonke	Total
No. of THPs in pop.	3000	8000	3500	1700	**1500**	840	3000	2700	1990	1200	**25,430**
No. of THPs operating	2000	2500	3000	900	**600**	590	700	900	782	750	**12,722**
No. of THPs on register	1200	1500	1000	800	**400**	150	110	400	492	250	**6302**
No. of THPs trained	200	600	325	200	**348**	20	45	220	411	350	**2719**

Source: Indigenous Health Care Systems, University of KwaZulu Natal. (Zululand not included due to missing data)

2.1.1| GLOBAL AND SOUTH AFRICAN POLICY FRAMEWORK

The South African indigenous health system dates back to ancient time Since the late 1970s, a number of international resolutions have been passe to promote regulation of traditional medicines and implementation of specif measures to govern traditional health practitioners.

From the early 1990s, the World Health Organisation (WHO) has advocated f the inclusion of THPs in the national AIDS programmes. In 2003, the 56th Wor Health Assembly of the World Health Organisation resolved, under its glob strategy on alternative medicine, that its member states must ensure that the health care systems promote and support provision of training and, if necessar retraining of traditional health practitioners, and a system for the qualificatio and/or accreditation or licensing of the practitioners [4] .

After five years of debate, the South African government enacted the Tradition Healers Act of 2004 in order to integrate about 200,000 traditional healers in the mainstream of primary health care. According to Clause 5e, the Interi Traditional Health Practitioners Council of South Africa must promote ar develop interest in traditional health practices by encouraging researc education and training. Clause 6.2a explains that the Council must promot regulate, and liaise between traditional health practitioners and other heal professionals registered under any law [5]. This Act affirms the dignity and respe of traditional medicine and offers a framework to ensure the efficacy, safety ar quality of traditional health care services from registered and trained tradition healers. It also provides management and control over regulations, training ar conduct of practitioners.

5. *Traditional Healers Act, Chapter 2 section 5e and 6.2a.*

2.2 | LITERATURE REVIEW

In South Africa, the traditional health system can be described using four broad aspects:

1. It is a holistic approach that focuses on the whole person's health rather than particular organs or disorders
2. The body, spirit and environment (mainly spiritual and social) are all considered important to one's health
3. The traditional healers use rituals, divination (getting information through supernatural ways), faith healing, offerings, herbs and other naturally derived medicines
4. There are different types of traditional healers – *inyangas* who are skilled in natural medicines, *sangomas* who heal through communication with ancestral spirits (spiritualists), traditional birth attendants and traditional surgeons.

Despite the South Africa Traditional Healers Act, the traditional health system holds a somewhat ambivalent position in African society. The traditional healers retain strong support in predominantly rural areas (such as Umkhanyakude district), but appear to be regarded with some distrust by health professionals in the Department of Health. There is a considerable amount of anecdotal evidence to suggest that traditional healers are regarded with, at best, suspicion, and, at worst, derision by some of the health professionals working within the

Typically, a person who visits a traditional healer presents a health problem, the symptoms of which the traditional healer then treats. (Note that usually traditional healers do not visit patients. The patient must go to the traditional healer.) Some of these treatments involve making small cuts or punctures in the skin using a razor blade or sharp object and then applying muti (medicine) to the affected area. It is also not unusual for patients to receive treatments that involve the use of emetics and enemas.

An extremely sick patient may be invited to stay with the traditional healer and his or her family while treatment continues. In other words, it is not uncommon for sick people to be invited into the traditional healer's home where they share sleeping areas, food, utensils and toilets.

All of the practices described above have attendant health risks for the patient, the traditional healer and the traditional healer's family, particularly if the patient is suffering from a contagious disease such as tuberculosis, or is HIV-positive.

Department of Health. According to the African Health Care Systems Research Network (*Colvin M et al, 2001*) efforts to improve the care and treatment of South Africans with HIV/AIDS are often hampered by misunderstandings and poor relations between western health care workers and community-based traditional healers. Colvin *et al* admit that the new South African legislation on traditional healers is vital to guiding intervention efforts aimed at resolving these differences.

Doctors for Life International, a body that represents about 600 conservative-minded, pro-western physicians view the traditional healers sector as unscientific and to be kept out of South Africa's health care system. The body maintains that the practices of traditional healers are not based on empirical truth and licensing them will have a negative impact on patients and the economy of South Africa .[6] Masauso *et al* (1996) noted that there is an unresolved argument that traditional healers perceived modern medicine as treating only STD symptoms, but not curing them. WHO[7] also noted that South African men felt that STDs were better treated by traditional healers than by the conventional health services.

The baseline assessment study conducted by AMREF in 2005 indicated that many of the traditional healers interviewed felt that they were marginalised. They cited a number of instances in which, prior to the intervention, both they and their patients were given short shrift by the doctors and nurses they came into contact with at clinics and hospitals.

Despite mixed views from professionals and a renewed interest by science in documenting best practices in traditional medicine for the cure of major communicable diseases like HIV and TB (Masauso *et al,* 1996), political interest in this subject has resulted in the passing of the Traditional Healers Act of South Africa. Furthermore, Dr Kgosi Letlape, the chairperson of the South African Medical Association (SAMA), remarked that many people utilise traditional healers and getting them registered with standardised safety practices is a good notion .[8]

Most researchers in South Africa (Abdool Karim *et al*, 1994; Masauso *et al*, 1996; Wilkinson *et al* 1999; Colvin et al, 2001; Liverpool *et al*, 2004; Threethambal *et al*, 2002) have concurred that integration of traditional healers into South Africa's primary health care system is vital for effective management of communicable diseases.

6. *Jerome Cartillier. Licensed to heal: South Africa moves to recognize traditional healers. Agence France-Presse - September 8, 2004.*
7. *Bauni EK, Garimoi CO, Maharaj P, Mushingeh ACS, Neema S,. Ngirwamungu E, and Riwa P. (1998). Attitudes to sexuality and family planning. World Health organisation. Progress in Reproductive Health Research, No. 48 part 2.*
8. *Ibid.*

Traditional healers offer a vital, innovative and effective approach in Africa's AIDS prevention and control programmes, especially at primary health care level (Liverpool *et al*, 2004). A study conducted by Threethambal *et al* (2002) in Durban, KwaZulu Natal noted that traditional healers have always been an integral part of health care in South Africa. However, their contribution in the sector remains unknown. It was reported that 210 out of 300 (70%) patients consulted a traditional healer (*sangoma*) for the first time. The researchers recommended that health care professionals need to be proactive in integrating traditional healing with westernised practices to promote health for all.

In line with this recommendation, another study conducted by Shai-Mahoko in 1996 in North West Province of South Africa noted that 17 out of 26 (74%) traditional healers referred their clients to a western trained physician. Wilkinson *et a*l (1999) reported that 84% of patients on TB treatment preferred having a traditional healer as their treatment supervisor. Ninety-two percent (92%) of the traditional healers were willing to act as treatment supervisors for TB patients and were also keen to negotiate collaboration with health services since 88% of them reported that they had previously referred their patients with possible TB to hospital. Wilkinson *et al* concluded that the potential for collaboration between traditional healers and TB treatment services in KwaZulu Natal province is high.

Colvin et al (2003) reported that there were no significant differences in treatment outcomes for patients supervised by traditional healers and those supervised by people other than traditional healers. However, they noted that 80% of TB patients who had completed treatment reported high levels of satisfaction with the care received. Thus, it was concluded that traditional healers make an effective contribution to TB programme performance.

With no vaccine or cure in sight, the need to scale up innovative and best practice models that are proven to have collectively contributed to reversing the infection rates from the highs of above 30% to the lows of 6% is urgent.

2.3 | THE TRADITIONAL HEALERS PROJECT IN SOUTH AFRICA

Traditional health practitioners (THPs) constitute a valued and trusted primary health care service. Over 60% of rural inhabitants in South Africa seek health advice and treatment from traditional healers before visiting a mainstream primary health care service.

Traditional healing in South Africa is a form of holistic medicine, examining ill health from a social, psychological, spiritual and physical perspective. Traditional health care delivery provides a client-centred, personalised approach that is culturally appropriate and tailored to meet the specific needs of the patient. It embraces a wide range of practices including herbalism and spiritualism, and practitioners such as diviners, priests and faith healers. Traditional healers have long been recognised for their expertise in treating sexually transmitted diseases and play a crucial role in addressing psycho-social problems, even in the context of rapidly changing societies.

In South Africa, THPs treat large numbers of people infected with, affected by or vulnerable to HIV/AIDS and TB. They, therefore, represent an important and effective medium to reach vulnerable communities with correct information regarding HIV/AIDS and TB and effective prevention methods. They comprise an accessible, available, affordable, trained and experienced human resource pool.

AMREF recognises the importance of THPs in rural South Africa and views their role in preventing and mitigating the impact of HIV/AIDS and TB as pivotal in the organisation's overall community-focused response to the epidemic.

In developing an inventory of successful HIV/AIDS interventions, AMREF in South Africa identified a model of best practice emerging from a successful collaboration between a traditional healers' forum and a primary health care programme in Standerton, Mpumalanga province. The model was fashioned around deployment of THPs into Standerton Hospital to offer counselling and HIV prevention training. In 2006, AMREF documented the impact of this model and, recognising the scope to replicate and build on this effective initiative, the organisation developed an innovative and successful project in Umkhanyakude, KwaZulu Natal.

The project aimed to harness and build the capacity of THPs to respond to and more effectively manage HIV/AIDS and TB services in Mtubatuba municipality. It also aimed to facilitate strong community participation and partnerships between traditional medical systems and biomedical systems through integration of community-based and national health care services.

The initiative sought to document a model of community-based health information system in which traditional healers would document their patient profiles and make referrals to the main health care system. This approach had gained momentum in South Africa and offers an innovative and ambitious intervention in the fight against HIV/AIDS and TB (Liverpool *et al,* 2004).

The objectives of the traditional healers programme are:

1. To increase acceptability and awareness of the role of traditional healers in health delivery
2. To improve the capacity of 80 traditional healers to support the management of HIV/AIDS, STI, TB and child care in Mtubatuba
3. To improve the quality of traditional healing in Mtubatuba
4. To improve access to voluntary counselling and testing services in Mtubatuba
5. To document and disseminate a best practice model of integrating traditional healers.

2.3.1| BACKGROUND

Between 2003 and 2006 AMREF documented an inventory of successful HIV/AIDS interventions in eastern and southern Africa. Good practices and lessons learnt from these interventions were disseminated and some were replicated and/or scaled up. In South Africa, the Standerton Traditional Healers Project was documented.

In 2004, AMREF conducted an assessment on the capacity of community organisations, institutions, and structures (household heads) in the care and support of Orphans and Vulnerable Children (OVCs), People Living with HIV and AIDS (PLWHAs) and families affected by HIV/AIDS. Among the findings were challenges faced by traditional healers in dealing with HIV/AIDS and TB, especially lack of training, lack of necessary equipment like gloves and razor blades, patients not revealing their status thus exposing them to infection, and lack of space to nurse patients in their homes.

The organisation later developed the Traditional Healers Project and implemented it in Mtubatuba sub-district of Umkhanyakude District in KwaZulu Natal province. Mtubatuba is one of the five sub-district municipalities in Umkhanyakude district with a population of about 35,000, largely rural and peri-urban Zulu-speaking communities. The area has an estimated 600 practising traditional healers (see Table 2.3).

AMREF set up a VCT centre in Dukuduku village, about six kilometres from St Lucia, a small coastal holiday resort, and 30 kilometres from the larger town of Mtubatuba. This centre is the focal point for the traditional healers' initiative and serves as a link between them and the health care system.

2.3.2 | ACTIVITIES

Following consultations with the THP leaders, it was decided that the most effective way to achieve the project's objectives was to establish a relationship of trust, transparency, honesty and accountability with the traditional healers and their leaders, build on their existing knowledge and practices and develop a learning intervention that applied the principles of participatory and experiential learning.

At an initial meeting with 30 THPs and their leaders, held in April 2004, it was noted that traditional healers held negative feelings towards most outside organisations and institutions, particularly those that conducted research and published their findings without consulting them. AMREF dealt with the hostility by being honest and open from the project inception. The organisation was realistic about what the project could and could not achieve. Several meetings were held with the executives of the Traditional Healers District Committee and Department of Health officials from different tiers, including the District Director of Health, the HIV/AIDS unit and district primary health care co-ordinators.

After extensive community and leadership consultative meetings with the local stakeholders , a cohort of 80 THPs were selected. They comprised 60 females and 20 males. The criteria used in the selection included area of residence (Mtubatuba), whether or not one was registered with the THP Council, gender (empowerment of women), literacy level as defined by ability to read and write, interest and availability of the traditional healer for training and mentoring.

Out of the 80 selected, 68 (85%) were trained as traditional healers. Out of these, 25% were registered with the KwaZulu Natal Traditional Healers Council. The youngest traditional healer was 26 years and the oldest, 88 years. Forty-six percent (46%) were between 25 and 55 years. Fifty percent (50%) of the participants had never attended formal education, while 18% studied up to standard two. Only 6% had metric level education and 25% had attained secondary level education.

The cohort of 80 THPs received training and mentoring over the course of a year in the following areas:

1. HIV/AIDS
2. VCT
3. Home-based care
4. TB and directly observed treatment short-course (DOTS)
5. STIs
6. Antiretroviral therapy

7. Prevention of mother to child transmission (PMTCT)
8. Community-integrated management of childhood illnesses (cIMCI)
9. Care of orphans and vulnerable children including grants available to them and how to apply
10. Project management
11. Financial management
12. Ethics in health
13. Leadership

Training content and methodologies were appropriate to the THP audience in terms of both literacy level and context. The choice of training materials and teaching methods were based on existing knowledge and the communication methods used by traditional healers. They actively contributed to the content of the training materials which captured their "real life" experiences, approaches and methods. They also provided input on how these could be improved, culminating in training packages for traditional healers developed by traditional healers in their own language (Zulu). In addition, training times and days were negotiated in order to ensure that the participants still had opportunities to see their clients. Overall, the training was done in a spirit of strengthening the traditional healers' current practices, rather than making them "western doctors."

A Project Steering Committee (PSC) of key stakeholders was formed, trained by AMREF in DIME (Design, Implementation, Monitoring and Evaluation) and tasked with managing the project together with the project manager. Over 50% of the PSC members (25) are THPs. This ensured full local ownership and increased participation by THPs and other key stakeholders. Regular monitoring and evaluation was conducted to review the project's logical framework. This was done through quarterly review meetings, project reporting, and final evaluative research. Evaluative research data was collected using questionnaires, in-depth interviews and focus groups administered by trained THPs to ensure full participation and cultural sensitivity.

Before the intervention, a situational analysis was conducted to assess contemporary knowledge, attitudes, practice, treatment and capacity of THPs with reference to HIV/AIDS and TB, as well as the communities they serve and their willingness to integrate with primary health care service providers. This phase aimed to identify the most appropriate interventions to strengthen traditional healing and integrate it with primary health care in a sustainable and mutually beneficial manner.

It was assumed that capacity building of THPs in identified areas of training and mentoring, and linking them to the health care system would result in:

1. Increased acceptability and awareness of their role in health delivery
2. Improved capacity to support the management of HIV/AIDS, STIs, TB and child care in Mtubatuba
3. Improved quality of traditional healing and access to VCT services.

2.3.3 | RESULTS AND ACHIEVEMENTS

The Umkhanyakude Traditional Healers Project has achieved a number of outcomes.

Improved quality of traditional healing services

Evaluative research findings conducted in 2007 indicated that the project had a positive impact on the quality of traditional healing in the Mtubatuba sub-district. The quality of traditional healing among the THPs involved in the project greatly improved as a result of the training and mentoring. Prior to the inte rvention, six out of 30 interviewees had no toilet and only one had two toilets – one being used by the family and the other by the patients. Today, all of the traditional healers have toilets and are actively protecting their own health, the health of their families and patients, particularly where potentially contagious diseases are concerned.

Twenty-five (25) out of 80 traditional healers who did not have means to dispose of faecal waste in their facilities or homes have now built pit toilets. These were constructed after AMREF negotiated with the District Water and Sanitation Department to allow the THPs to participate in their waste disposal planning. Reports also indicate better control of infections through hygienic waste disposal practices (digging holes and burning).

Improvements were also observed from the range of structural changes, such as having waiting room facilities for clients and building shelves to store medicines, having separate bottles or containers for different medicines, sterilising treatment equipment, avoiding sharing razor blades by using one corner and breaking it off after use and using gloves when handling clients' body discharges.

All the traditional healers now have vegetable gardens as compared to earlier when only 22 out of the 30 interviewees reported having vegetable gardens. In addition, 12 of the interviewees had made significant improvements to their food gardens as a result of the intervention.

All the traditional healers now provide home-based care and counsel, and advise their patients on a number of health- and nutrition-related issues. They also provide oral rehydration therapy (ORT) for the treatment of dehydration due to diarrhoea.

Referrals

Twenty-five (25) out of the 30 traditional healers interviewed stated that they had referred patients to a VCT, local clinic or hospital for TB. Additionally, 17 had referred patients for HIV/AIDS, nine for diarrhoea, two for 'fits', two for chicken pox, two for malaria, two for diabetes, one for 'sores', one for 'miscarriage' and one for 'eye problems.'

All those interviewed during the evaluation stated that they were now able to identify the symptoms of STIs, AIDS and tuberculosis and referred patients to either a VCT, local clinic or hospital. The number of referrals varied from 'about one or two a month', to the norm of 'four or five per month', and, in the case of two traditional healers, 'over 800' (over a 12-month period).

Prior to the AMREF intervention, none of the traditional healers interviewed as part of the evaluative research had ever referred a patient either to a local clinic or hospital for HIV testing or an AIDS-related condition. They could not identify the symptoms of HIV/AIDS infection or TB, and would continue to treat a patient presenting with these symptoms, literally to death. In addition, THPs now refer all potential THP trainees (amathwasa) for HIV testing before enrolling them.

All of the traditional healers interviewed now use the Traditional Healers' Referral Letter when referring patients for treatment and the Patient Form for Traditional Healers to keep a record of their referrals.

Building partnerships and advocating for acceptance

An assessment of the knowledge and attitudes towards and perceptions of health care professionals towards traditional health care practitioners was carried out prior to the intervention. Table 2.4 highlights the responses from health professionals.

Table 2.4 : Perceptions of health care professionals towards traditional healers (baseline)

Proposed attitude	Agree	Disagree
THPs are fakes who pretend to cure AIDS	45%	41%
THPs can cure AIDS	13%	62%
Some THC practices could increase risk of HIV infection	78%	15%
THPs cannot be trusted to treat people with HIV/AIDS	31%	47%

Proposed attitude	Agree	Disagree
THPs have all the knowledge needed to treat people living with HIV/AIDS	19%	65%
THPs are ideally placed in their communities to provide effective support for people living with HIV/AIDS	47%	34%
Traditional medicines can play a role in the treatment of PLWAs	48%	32%
THPs are well placed to provide DOTS for TB	37%	51%
THPs can be trained to provide DOTS for TB	76%	20%

It is significant that all the traditional healers interviewed during the fina evaluative research survey maintained that their standing within the communit had improved and their relationships with the doctors and nurses with whor they now interact more frequently had changed from 'bad' to either 'fair' o 'good'. These findings were further supported by the medically-trained nursin personnel who confirmed that the relationship between the traditional healer involved in the project and the medical personnel with whom they cam into contact had 'greatly improved'. In addition, there was strong evidenc based on enquiries and requests received by AMREF, that a number of th traditional healers who were not included in the initial project were intereste in undergoing the training.

As noted in Table 2.4, the health professionals acknowledged that traditiona healers do play a role in assisting with DOTS, or could be trained to provid DOTS. Sixty-six percent (66%) of those who filled out the questionnaire an 76% of the interviewees stated it would be an asset to have a THP on a team o medical practitioners involved in prevention and treatment of TB.

Improved capacity to support the management of HIV/AIDS

There was consensus among all the stakeholders (health care workers an managers) interviewed that the roll-out of ARV treatment had improved as result of the project. First, over half of the traditional healers on the project a now referring patients they suspect of having AIDS for testing and treatmer Second, all of the traditional healers have been trained to recognise th symptoms of HIV/AIDS. Third, there is strong evidence that the tradition healers who were part of the project are being integrated into the heal

system and are now (a) actively encouraging patients they suspect of having AIDS or being HIV-positive to go for testing, and (b) are providing support and counselling to patients taking ARVs.

Formation of partnerships with the formal health care system

Formal health professionals now acknowledge the role played by traditional healers in the health system. This is evident by the referral of clients back to traditional healers for monitoring and further support. The Umkhanyakude Traditional Healers' project has successfully established and strengthened community-based referral systems for HIV/AIDS and TB care in Mtubatuba. Traditional healers are considered valuable and effective by the Department of Health. An estimated 2500 clients were referred to the formal health services for VCT and a further 108 clients as TB suspects following the intervention (between October 2007 and August 2008). Traditional healers who participated in the project have been provided with home-based care kits that are replenished by local clinics and hospitals. These kits are basically small rucksacks containing rubber gloves, condoms, bandages, disinfectants, etc.

Establishment of a networking system

In a dramatic departure from conventional practice, all of the traditional healers who were part of the AMREF initiative are now part of a focus group (continuation of the Project Steering Committee) which meets on a monthly basis to deliberate on issues of common concern (e.g. referral of patients, traditional medicine updates, and collaboration with government departments such as Forestry and Environmental Health and Wildlife for medicines). These meetings are also used as platforms to interface with the Department of Health and improve collaboration mechanisms.

Facilitating access to VCT services

Another major output of the project relates to the role of traditional healers in facilitating VCT to improve access to quality counselling and testing at primary health care level. By being more aware of the importance of VCT and actively encouraging clients to know their status means that more members of the community will be accessing VCT. Traditional healers indicated that they had learnt counselling skills that enabled them to persuade their clients to visit the VCT centre. Their role in this respect has often involved some of the healers going to the VCT centre with their clients to provide support.

Interestingly, some participants felt that the counselling skills taught were an extension of existing functions that THPs perform in their day-to-day work,

because they listen to people and allow their stories to emerge without rushing clients, which was seen as a sign of respect for the person. Respect was perceived as an important part of healing that is inherent in traditional healing practices but is lacking in Western health practices:

"We treat people with more respect than these doctors and nurses. They even treat HIV positive people badly ... they just discharge them and tell them to go home, then we have to care for them so that they can die with dignity. Even a sick person must be respected and we help people that way."

All the traditional healers interviewed demonstrated pride and confidence in their own abilities, and stated that they are more respected within the community and that their relationships with the Department of Health has greatly improved. In fact, all of the traditional healers interviewed believe that their patients now receive preferential treatment from the doctors and nurses.

A number of the traditional healers who were participants in the project are now mentoring traditional healers who were originally excluded from, or who chose not to be part of, the project.

The above results allude to strengthened relationships amongst THPs and the Department of Health clinics that has been harnessed and channelled towards the development of systems for internal mentoring, information sharing and patient referral. Some THPs have reported increased confidence in their health care provision.

"We have been empowered to feel proud of what we are doing and we are committed to do it better for the safety of our patients and ourselves. We are now able to talk to our children freely about HIV and AIDS and we share the information on the pamphlets with our families"

Mrs Tembe
Traditional health practitioner

2.3.4 | LESSONS LEARNED

Lesson 1: It is possible to develop a highly effective learning intervention for traditional healers who are barely literate and increase their effectiveness in managing clients, with support from the formal health system

Participants reported that they had been taught to recognise signs and symptoms that were suggestive of TB and HIV/AIDS. This has led to an increased improvement in their management of these cases. They were also able to distinguish between idliso and TB, by first referring clients who presented with weight loss, coughing and night sweats for sputum tests. Only when TB has been excluded do they proceed with their own treatment. Similarly, when someone comes to them indicating that they have the calling to be traditional healers and presents with symptoms suggestive of HIV infection, they first refer them for VCT in order to exclude HIV/AIDS. This was particularly important because the presentation of idliso, the calling, TB and HIV/AIDS can be confusing as all have similar symptoms including weight loss and coughing.

Thus, it is possible to develop a highly effective learning intervention for traditional healers who are illiterate or barely literate and increase their effectiveness in managing TB, HIV/AIDS and STI clients, with support the from health system. In addition, traditional healers see these trainings as complementary (and not a replacement) of their holistic approach on treatment. When traditional healers are given up-to-date and accurate health-related information and are properly trained, they will make appropriate changes in their working environment and abandon potentially harmful practices and treatments.

Lesson 2: One can positively change both the role and function of traditional healers in the community

When traditional healers and health professionals are given a practical and effective way to work together, both groups demonstrate a willingness to change their behaviour and help each other.

While traditional healers expressed negative sentiments about their relationship with western medicine, they made it clear that the project had had a positive impact on the overall practice of traditional healing in the area. One important factor was the relationship among the THPs themselves. The participants indicated that they had gotten to know one another better, which had led to closer co-operation.

Securing buy-in to the project from traditional leadership structures had also led to increased prominence of THPs in the overall functioning of the community, with the chief setting aside time at each meeting to confer with them and

monitor how the project was proceeding, as well as consulting on other issues
Traditional healers were keen to continue playing a meaningful role within
their communities and were committed and sensitive to the cultural issues that
impact on their patients' behaviours. They were also interested in working in
partnership with the Department of Health, not as "western doctors or nurses".

2.3.5 | CHALLENGES AND RECOMMENDATIONS

Key challenges that emerged from the project included lack of resources on the part of the traditional healers, operational challenges in maintaining the referral and patient records system, and challenges related to the negotiation of a relationship between the THPs and the mainstream medical services.

Lack of resources

While a number of gains regarding resources and infrastructure development were reported, traditional healers spoke about difficulties they experienced in implementing all the lessons learnt from the training, such as lack of water and resources needed to build extra rooms for proper home-based care. They highlighted how these deficiencies often put their own families at risk for infection:

"These patients are discharged from the hospital and have nowhere to go . . .I cannot chase a sick person away so I accommodate them in the same hut with my children."

"It's not safe for my family but what can I do? They don't have anywhere else to go and you can't throw a person away like a dog,. . .so they sleep with the children."

"It would be good if we can get help to build toilets, waiting rooms and a place where they can sleep so that they do not sleep in the same room with my children."

Lack of government support for the work of traditional healers, and their lack of skills in securing funding was also identified as a challenge. All the THPs spoke about their own poverty as well as that of the clientele. The latter resulted in them not being able to make a living from their work, as they were unable to charge fees and often had to settle for payment in kind, such as live chickens.

A key challenge relating to personal capacity and historical access to resources was the problem of illiteracy and language difficulties among THPs. The project did, however, attempt to deal with this challenge in very creative ways. For example, the current materials being used have all been or are in the process of being reworked so that those who do not read or write English can use them. For example, the referral form that has been developed for THPs to refer clients to hospitals is an example in this respect – all items are indicated by an image that is easily recognisable to THPs and hospital staff.

Tension between western and traditional healing practices

While THPs were learning to work together, they still complained about the attitude of the mainstream, western health care settings which they described as undermining. For example, they never received any feedback from clinics about clients that they had referred for assessment and treatment, and it was felt that the referral system was one-way, with western medicine not referring to THP cases that they were unable to tackle.

This area of collaboration should be the next step in the project, i.e. working with clinics to facilitate a more co-operative, equal relationship between the two.

"They [doctors] never look at the patient and how they have improved. Why do they want to see the medicine I used and not look at what has happened with the person? I will never show them what I use."

"I know what my medicines are. These doctors don't even know what is in the pills they give, or how much of what is in there. I search for my herbs according to what has been revealed to me (by ancestors/spirits), so each person who comes to me gets what is right for him or her. These doctors just use the same thing for everyone....and then they always demand to see what my medicines are."

The traditional healers are critical of the methods of western medicine, particularly the distancing of practitioners from their clients and the materials they use. The tension between these two systems was experienced not only by THPs but also from the health workers. Interviews with health care providers at the local clinics and the hospital indeed indicated an ambivalent relationship with THPs, with some of the participants being negative about traditional healing while others felt that there was merit to traditional methods of healing in as far as they could cure some illnesses:

"They know some things – for example asthma, they can cure it with the water that comes out when you lift a snail up... you know, those few drops that come out of the snail, they really work."

Health worker

"I have seen people with STIs who have used a traditional healer's treatment and have been cured, but then I'm not sure because they keep coming back, ...so I don't know if they have been healed and got re-infected or what."

Clinic nurse

It is worth noting that more than a third of the health professionals (34%) were averse to any kind of collaboration, posing some considerable resistance to the success of the project. However, despite such misgivings from the health workers, the majority were prepared to collaborate with THPs in the context of HAST (HIV, AIDS, STI and TB) prevention, treatment and care. More intense education and awareness raising among mainstream health professionals would overcome some of these barriers.

2.3.6 | CONCLUSION

Traditional healers who have undergone practical training and participated in strengthening of community-based patient management and referral system have significantly contributed to the early detection of diseases such as HIV/AIDS and TB. There is strong evidence to suggest that the Umkhanyakude Traditional Healers' Project has been a success, especially in imparting knowledge and skills designed to enhance the practices of traditional healers and to strengthen linkages with the formal health system. The intervention has been a significant factor in strengthening the community-based referral systems for HIV and AIDS care in the district. Traditional healers have also become a valuable and effective ancillary to the Department of Health. Those interviewed during the evaluative research demonstrated more pride and confidence in their own abilities. They are more respected within the community and their relationships with health department personnel have greatly improved. In fact, all of the traditional healers interviewed during evaluative research were of the opinion that their patients now received preferential treatment from the doctors and nurses they are referred to. The lessons learnt from the results achieved through traditional healers project are to be considered by any interventions focusing on capacity building of traditional healers.

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3

THE CASHE MODEL

AN INNOVATIVE WAY OF IMPLEMENTING DECENTRALISED WATER AND SANITATION SERVICES

By
Walude Mtwalib

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ABSTRACT

Although deaths and illnesses related to poor sanitation are entirely preventable, millions of people in developing countries continue to lose their lives every year. It is estimated that 80% of the disease burden in Uganda is associated with poor sanitation while diarrhoea alone accounts for 19% of all infant deaths. Despite the explicit commitments expressed by Uganda's decentralisation policies, the bulk of the water and sanitation activities are still implemented directly by district authorities.

The CASHE model promotes capacity building of communities to implement their own water and sanitation services with emphasis on generating demand for sanitation and hygiene through social mobilisation by community resource persons. The result of the project activities has been cost-effective and equitable investment in sanitation and hygiene which optimizes utilisation of available community resources. It proved that community health workers when equipped with the necessary skills and knowledge can be effective in delivery of water and sanitation programmes.

ACKNOWLEDGEMENTS

I would like to acknowledge Carolyn Idduso, Lilian Kamanzi and the WASUP project staff of AMREF in Uganda who were involved in reviewing and providing comments on the initial drafts of the case study. I would also like to thank Dr. Thomas Kibua for his guidance during the compilation of the study and Betty Rabar for editing the final document.

Many others reviewed and made comments on the countless versions of the case study. They include: the senior management team of AMREF in Uganda; members of the national sanitation working group; the project implementation teams in the districts of Kabale, Soroti, Kampala, Amuru, Gulu, Kitgum and Pader; and core working groups of sanitation, hygiene, operation and maintenance and CBMIS.

I am grateful to Madrid City Hall, Spain for the financial assistance provided for implementation of the project activities.

ACRONYMS AND ABBREVIATIONS

AMREF	African Medical and Research Foundation
CASHE	Community-Based Approaches to Sanitation and Hygiene Education
CBMIS	Community-Based Management Information System
CHC	Community Health Club
CORPS	Community Own Resource Persons
GOU	Government of Uganda
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
ISH	Integrated Sanitation and Hygiene
LeaPPs	Learning for Change in Practice and Policy in Sanitation
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoES	Ministry of Education and Sports
MoWE	Ministry of Water and Environment
MoH	Ministry of Health
MoU	Memorandum of Understanding
NETWAS	Network for Water and Sanitation
NGO	Non-Governmental Organisation
O&M	Operation and Maintenance
PEAP	Poverty Eradication Action Plan
PHASE	Personal Hygiene and Sanitation Education
PHAST	Participatory Hygiene and Sanitation Transformation
PHCs	Parish Health Committees
PPP	Public Private Partnerships
PSOs	Private Sector Organisations
SHC	School Health Committee
TOTs	Trainer Of Trainers
UNICEF	United Nations Children's Fund
UNPAC	Uganda National Plan of Action for Children
VHT	Village Health Team
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WSC	Water and Sanitation Committee

3.1| THE PROBLEM

Although deaths and illnesses related to poor sanitation are entirely preventable, millions of people in developing countries continue to lose their lives every year. It is estimated that 80% of the disease burden in Uganda is associated with poor sanitation while diarrhoea alone accounts for 19% of all infant deaths. Currently, about 40% of families do not have latrines. There are, nonetheless, some communities where this exceeds 90%.

Since the formulation of the Kampala Declaration on Sanitation in 1997, a number of interventions have been initiated to promote sanitation and hygienic practices at national level. However, until recently, the water and sanitation sector had failed to incorporate sanitation and hygiene promotion among its priority actions. The 2006 national latrine coverage stands at only 58% -- a minimal increase from 55% in 2002 and 49% when the Declaration was signed in 1997 .[1]

Sanitation and hygiene improvement have lagged behind water provision. Policy implementation is weak and yet to be fully decentralised to effectiv reach the target groups. Other hindrances include unco-ordinated planning and limited involvement of stakeholders. Consequently, the targeted health-related outcomes presented in Table 3.1 may not be achieved.

Table 3.1: Trends for health-related outcomes

	1990	1995	2000	2005	PEAP target 2005	MDG 2015 target
Infant mortality rate (IMR/1000 live births)	122	81	88	79*	68	Reduce IMR by 2/3 i.e. to 41 per 1000
Under 5 mortality rate (U5MR/1000 live births)	180	147	152	136*	103	Reduce U5MR by 2/3 i.e. to 60 per 1000
Maternal mortality rate (MMR/100,000 live births)	527	506	505		354	Reduce by 3/4 i.e. to 131 per 100,000

Source: HSSP II 2006-2010, table 1.1, pp 2-3.

*Data marked * are obtained from the WHO database*

1. *Health Sector Strategic Plan II 2005/06-2009/2010, Volume I, pp31*

Without good sanitation, there can be no sustainable development in health education, the economy and livelihoods. Poor sanitation is associated with i health, low productivity and poverty. An average household spends up to UgS 20,000 (approx US$ 10) per month on medical expenses due to sanitation related diseases. Despite all this, sanitation is still poorly financed with no precis data on funding levels. However, for every UgSh 2,000 invested in sanitation a average benefit of UgSh 14,000 would be realised mainly because of bette health.

3.1.1| THE ROLE OF THE GOVERNMENT

Over the past decade, the Government of Uganda (GoU) has undertaken a range of policy and institutional reforms to improve sanitation and hygiene. In recognition of its impact on the national disease burden, particularly high diarrhoeal disease morbidity as well as infant and child mortality and morbidity, sanitation is an increasing priority at the national level. It is a key priority in the government's environmental health policy, and is also supported by the 2004-2008 Poverty Eradication Action Plan (PEAP) and the country's commitment to the MDGs.

A key reform measure undertaken by the GoU in this context was the signing of a Memorandum of Understanding (MoU) between the Ministry of Water and Environment (MoWE), Ministry of Education and Sports (MoES) and Ministry of Health (MoH) in 2001 to clarify institutional responsibilities with respect to sanitation and hygiene and improve implementation at the district and community levels. The three agreed to put in place the following institutional arrangements:

- MoWE is responsible for planning sewerage service and public latrines in towns and rural growth centres and promoting hygiene around new water points
- MoH is responsible for hygiene and sanitation at household level
- MoES is responsible for latrine construction and hygiene education in schools.

However, the government still faces significant challenges in implementing the MoU, which has raised two key issues; (i) the need to improve the definition of roles and responsibilities at the district and lower levels and; (ii) the need for increased sanitation and hygiene financing to match and support the institutional responsibilities.

Within each ministry, there are policies and corresponding strategies, which address cross-cutting issues and promote full community participation. However, the dedication to allocate resources and the strategic linkages to do so are insufficient.

In spite of the explicit commitments expressed in Uganda's decentralisation policies, the bulk of water and sanitation activities are still implemented directly by district authorities, albeit vertically, under their departments of water, health and education. The limited capacity of stakeholders coupled with the weak implementation structures at community level has stifled the translation and dissemination of policies to targeted communities.

The verification and monitoring of the golden indicators [2] set by the Ministry o
Water and Environment in relation to the linkages between the national leve
and district level still needs to be properly defined. While for some indicator
clear targets are yet to be set, there is little community involvement in th
management information systems in place, a factor that is vital for enablin
them to make informed decisions.

2. *Sector performance report, Ministry of Water and Environment, 2005*

3.1.2 | HOW THE PROBLEM IS BEING ADDRESSED

The Ugandan water and sanitation sector has for more than a decade received substantial external support. The target for sanitation coverage by 2015 is 77% for rural areas and 100% for urban areas. In order to achieve these targets, a sound policy, legislation, and strategic planning framework has been put in place. This has created an enabling environment for the promotion of sanitation through the provision of regulations below[3]:

The 1995 Constitution of the Republic of Uganda states that: It is the duty of every citizen of Uganda to create and protect a clean, healthy environment. (Chapter 3, Article 17 j).

Public Health Act (1964) – according to this Act every citizen is obliged to have access to a latrine at his/her home (Chapter 269). It also requires that all places of work have latrines.

National Health Policy (1999) – the National Health Policy puts sanitation high on the list of health priorities. Under Section 8.1.2 Primary Health Care (PHC) Grants, sanitation improvement is one of the eight priority areas.

National Water Policy (1999) – one of the key directives under this policy is the promotion of sustainable provision of clean safe water within easy reach and good hygienic sanitation practices and facilities, based on management responsibility and ownership by the users.

Water Statute (1995) – one of the objectives of this statute is to control pollution and promote the safe storage, treatment, discharge, and disposal of waste that may pollute water or otherwise harm the environment and human health.

Local Government Act (1997) – this Act defines the roles of local councils in providing and promoting sanitation and hygiene services at commu¬nity and household levels. It provides for the decentralisation of powers and services from Central Government to Local Government with the aim of increasing local democratic control and participation in decision¬ making, and mobilising local support for development activities relevant to local needs.

Ugandan Plan of Action for Children (UNPAC, 1992) – this government policy document in the area of child survival and development makes provision for basic services to Ugandans in water and sanitation, as well as other services.

3. Ministry of Health, Environmental Health Division (1997), The Kampala Declaration on Sanitation

National Gender Policy (1997) – this policy emphasizes the government commitment to gender-responsive development.

Universal Primary Education Policy – this policy aims at the rapid acceleratio of primary school facilities and underlines the need for sanitation facili¬ties t support the expanded enrolments.

A number of undertakings, resolutions and strategies have been put in place t guide the implementation of the above regulations. The ***Joint Review Missio Undertakings*** recommend strengthening local government capacity to enac by-laws for increased enforcement of the Public Health Act (PHA) and othe related laws with an aim of improving environmental sanitation and hygiene i all districts by at least 30% from the current status, which is in line with the KD of 1997.

The ***National Health Assembly*** Resolutions commit local governments to th Kampala Declaration on Sanitation (1997) to enact and enforce by-laws (an ordinances) necessary to raise latrine coverage to 100% by October 2008. I addition, it also resolves to empower environmental health officers to effectivel enforce compliance with the provisions of the Public Health Act and relate laws.

The ***National Hand-washing Campaign*** aims to double the rates of hand washing with soap at critical times among those groups most susceptible t disease, especially children under five years through their mothers, caregiver and school children. The role of the district leadership in ensuring this includes

- Promotion of Public Private Partnerships (PPP) for hand-washing at distric level.
- Implementation of the campaign/strategy by incorporating hand-washin activities in annual work plans and ensuring adequate budgets fo implementing the activities.
- Designing/identifying innovations and promoting hand-washin competitions at lower levels.

The ***National Sanitation Week Campaign*** aims to maximise sanitation benefits through actions by leaders and other stakeholders, geared towards improvin sanitation in the whole country. Objectives of the national sanitation wee include:

- Demonstrating political will, leadership and support towards improvemen of sanitation and enforcing sanitation and hygiene by-laws

- Prioritising funding for sanitation through clear plans and budgets at all levels
- Raising awareness on the importance of sanitation and its impact on achieving MDGs
- Promotion and implementation of policies and actions for meeting the sanitation targets
- Mobilising communities to adopt appropriate practices through health education.

The ***National Integrated Sanitation and Hygiene (ISH) strategy for financing of improved sanitation and hygiene*** that aims to achieve national targets and the MDGs[4] produced by the sector in July 2006, is based on three pillars which outline the roles of different stakeholders, promotes development of ISH-rich district plans and ensures timely release of funds against the activities. The three pillars are:

- Implementation of a demand creation programme
- Implementation of a supply improvement programme
- Reinforcing an enabling environment.

The national strategies have all been decentralised at least to district level. All line ministries now operationalise their activities through local government staff based at district and sub-county levels. For water and sanitation, these include relevant departments of water, health services and education in collaboration with other partners like NGOs, private sector organisations, cultural and religious leaders.

Most local governments now develop sanitation strategic frameworks that are in line with the national policies and guidelines and are responsive to local needs and conditions. Common implementation strategies include: planning meetings at sub-county level for exemplary leadership commitment; adequate community mobilisation to promote sanitation activities through events such as support supervision and launching of sanitation campaigns; advocacy meetings at district and sub-county levels for improved sanitation financing strategy and; enacting and dissemination of by-laws.

However, mechanisms for implementation of these at sub-county and lower levels are still weak and resources for activating required capacity are not always available. In addition, spending on sanitation has remained stagnant over the past decade and actually fallen compared to other health investments. Approximately 0.001% of the Local Government Development Grant is used for

4. *10 Year Improved Sanitation and Hygiene Promotion Financing Strategy, 8 July 2006, Preface*

sanitation and hygiene activities. As reflected by a fragmented responsibilit among the three ministries of water, health and education, only 4% of the distric water and sanitation grant from the Ministry of Water and Environment is utilise for sanitation and hygiene activities while that from the MoH is approximatel 2% of the primary health care non-wage grant.

3.2 | LITERATURE REVIEW

Global Overview

Some 2.6 billion people worldwide – two in five – do not have access to improved sanitation, and about 2 billion of these people live in rural areas. Barely more than one-third of the population uses adequate sanitation facilities in west/central Africa (36%), southern Asia (37%) and eastern/southern Africa (38%). Global sanitation coverage increased from 49% in 1990 to 59% in 2004, and about 1.2 billion people gained access to improved sanitation facilities over that period. Yet the world is not making sufficient progress to meet the MDG sanitation target. To do so, the rate of improvement over the past 15 years would have to double between now and 2015. If current trends continue, there will be 2.4 billion people, partly as a result of population growth, without basic sanitation in 2015 (UNICEF, 2006)

There are notable discrepancies between urban and rural areas too. The global coverage rate of 59% reached in 2004 for sanitation means that 611 million people in urban areas and a staggering 2 billion in rural areas do not have access to improved sanitation. In rural areas, coverage with improved sanitation facilities rose from 26% in 1990 to just 39% in 2004. If that trend continues, coverage will have risen to only 49% by 2015, leaving half of the rural population without basic sanitation. In urban areas, demographic growth is alarming due to the projected increase in population. If efforts continue at the current rate they will push up coverage rates from 80% in 2004 to only 82% in 2015. Although the urban sanitation challenge is huge, rural sanitation appears to be nobody's concern. With 2 billion unserved in 2004 (two in every three rural citizens are unserved) and a projected 1.7 billion unserved in 2015, rural sanitation requires a massive concentration of effort to reduce substantially the urban/rural disparity in coverage (WHO and UNICEF, 2006).

3.2.1 | UGANDA'S CHALLENGES IN SANITATION PROMOTION

The Johannesburg plan of implementation of the MDGs advocates a holistic approach to meeting planned targets on water and sanitation. However, despite significant efforts to raise awareness and shift political will, progress on sanitation has been slow and uneven. In Uganda 40% of the population – over 11 million people – lack access to adequate sanitation. The access figures vary widely across the country ranging from 99% in Rukungiri to less than 2% in Kotido district. The Ugandan Health Sector Strategic Plan (HSSP II, 2004) pointed to convincing evidence that over 75% of Uganda's disease burden is considered preventable as it is mainly caused by poor personal and domestic hygiene and inadequate sanitation facilities and practices. The Infant Mortality Rate (deaths/1,000 live births) was 79 in 2005 against a target of 68 in the Poverty Eradication Action Plan (PEAP). The under-five mortality rate (deaths/1,000 live births) was 136 against a PEAP target of 103. The respective MDG 2015 targets are 41, 60 and 131 respectively.

In the past few years, the Government of Uganda (GoU) has made considerable efforts to put in place institutional arrangements. However, despite the efforts at both at the national and district levels, the progress is slow. Key challenges in the sector include lack of prioritisation and limited allocation of resources for sanitation and hygiene promotion (Water Sanitation & Hygiene report, 2008).

3.2.2 | SOME COMMUNITY-BASED SOLUTIONS

PHAST (Participatory Hygiene and Sanitation Transformation)

The Participatory Hygiene and Sanitation Transformation (PHAST) approach is a promotion tool used to accelerate and facilitate active community participation in sanitation and hygiene interventions (WHO, 1992). PHAST uses methods and materials that stimulate the participation of women, men and children in the development process. The approach relies heavily on training of extension workers and on the development of tool kits that are modified and adapted to reflect the actual cultural and physical characteristics of target communities. PHAST empowers communities in promoting health awareness behaviour change. However PHAST relies heavily on tools development, thus takes long to implement and realize results (UNICEF, 1994). Government extension workers have, however, failed to adopt the approach and still resort to the ineffective non-participatory approach that places emphasis on verbal dissemination of messages. Consequently, household improvements are regarded as individual rather than public concerns and efforts to improve hygiene and sanitation at this level are weak.

Community Health Clubs (CHCs)

Community Health Clubs (CHCs) enable community members to focus on sanitation improvement. It bonds community members, fosters shared ideology and culture of self development, helps community members develop common unity, develop confidence, foster structured participation in hygiene and health education, health awareness and understanding (NETWAS Uganda, 2008). Constraints include the tendency to rely on incentives (handouts), and cumbersome club meetings. The approach is applicable in settled and well organised/structured communities.

Sanitation and Hygiene Promotion through Schools

The concept of promoting health through schools has not been developed worldwide especially in developing countries. But the Personal Hygiene and Sanitation Education (PHASE) approach, first developed and implemented by AMREF in Kenya and scaled-up in Peru, Nicaragua, Zambia and Uganda, has proven that an integrated school approach to both curricular and co-curricular activities involving teachers, health workers, parents, policy markers in addition to community partnership as well as international networking is the key to effective sanitation and hygiene promotion especially among young children (Wamalwa, 2006).

The evaluation indicates that the PHASE approach increased children's knowledge on diseases. The pupils were tested on their knowledge of the causes symptoms and prevention of diarrhoea, and there was a significant difference between those in intervention and those in control schools. In terms of toile access, it emerged that the intervention schools had more VIP toilets compared to control schools. An analysis of where pupils washed their hands indicated that 87.2% of the pupils in intervention schools used leaky tins while 78.2% o those in control schools reported that they did not have a specific place to wash their hands. A significantly higher proportion of pupils in intervention school (87.5%) reported that they washed their hands after using the toilet compared to 47.5% in control schools. There was an increase of 15% in the number of school that conducted health education from the baseline (NETWAS Uganda, 2008).

To successfully promote healthy hygiene behaviours, there is need to shift the approach to promote community participation. Local innovation and creativity need to be fostered and supported. So far, engaging community health worker in this process has not been fully explored and has been AMREF's focus, a highlighted in the following section.

3.3 | COMMUNITY-BASED APPROACH TO WATER AND SANITATION

Background

AMREF implemented a two-year project titled Community-based Approach to Water and Sanitation in Kabale within all rural sub-counties from April 2004 to March 2006. The project was funded by Madrid City Hall, Spain, and implemented through sector departments of water, health and education in the district. It focused on sanitation and hygiene promotion targeting school age children and parents in catchment communities.

A stakeholder consultation at the inception stage with district authorities appreciated the proposed implementation approach and recommended that one school in each of the 17 rural sub-counties be developed to serve as a model for other schools. With limited AMREF staff on the ground, it was mandatory to implement the project through sub-county-based government extension workers. However a baseline survey, to establish existing water and sanitation conditions in the target schools and communities also revealed that about 60% of the extension workers were perceived as being non-effective in delivery of sanitation services to communities. This prompted the AMREF team to analyse underlying factors to this gap using the performance ranking framework below at district level (among technical and political leaders) and sub-county level (among local leaders and field extension workers).

Table 3.2: Performance ranking framework to assess effectiveness of water and sanitation interventions

VARIABLE / WASH COMPONENT	Relevant Policy	Relevant Policy Statement	Relevant Sector Strategy (ies)	Implementation Guidelines	Key Actors	Co-ordination	Collaboration	Roles and Responsibilities	Effectiveness of IEC materials	Management Information System	Financing Mechanisms	Level of Community Participation	Status of Community Management Capacity
Water supply provision	3	2									2	1	
Operation & maintenance		2									1	1	
Sanitation promotion		2									1	1	
Hygiene promotion		1									1	1	
Gender mainstreaming		1									1	1	
Total score		6									7	6	
Maximum score	15	18									18	18	
Effectiveness (%)		33									36	33	
Comments													

During interaction with different categories of leaders using the abo framework, analysis of results and their interpretation revealed the followi implementation gaps:

- Inefficient co-ordination/management at local government level
- Limited interaction between departments and the community
- Emphasis on project rather than programme approach
- Inadequate community influence over planning, financing, implementatio monitoring and control
- Limited community access to appropriate technologies and approach such as ecological sanitation and PHASE
- Inadequate community capacity to sustainably operate and maintain th established facilities
- Limited gender mainstreaming in water and sanitation services
- Weak appreciation of links between water and sanitation by th community.

The above reasons clearly implied weak co-ordination mechanisms at distri level and limited community participation in implementation of water a sanitation services. Therefore, a suitable model that promotes increase community participation in sanitation and hygiene promotion services a increases linkages between the district and community was developed. T

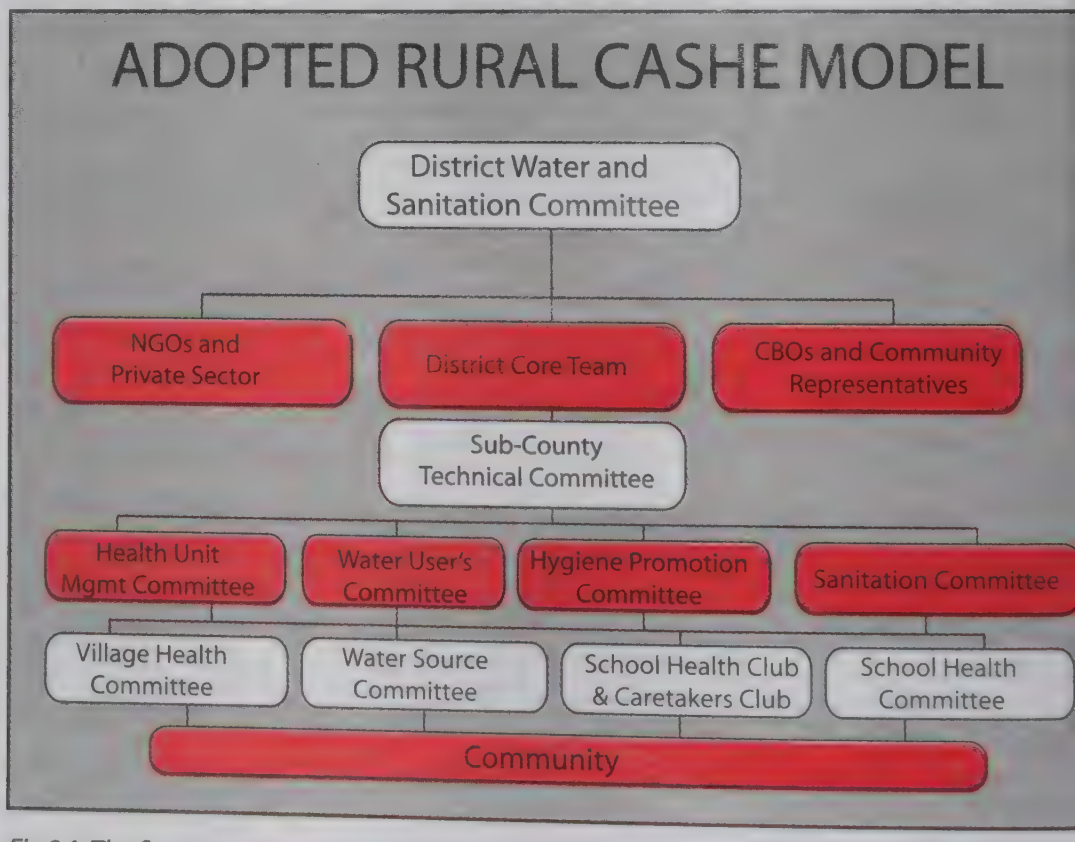


Fig 3.1: The first CASHE model

generic model was reviewed jointly with the district's leaders, extension workers and local leaders. The diagram below illustrates the resultant model that was developed at that time and named "The Community-based Approaches to Sanitation and Hygiene Education (CASHE) Model".

When fully developed and implemented, the model would result in:

- Improved co-ordination and collaboration mechanisms at various levels
- Streamlined and strengthened mechanisms for participatory monitoring and evaluation
- Clear and agreed roles and responsibilities of various stakeholders
- Scale-up of relevant approaches and technologies at community level
- An information system that is managed by both the community and district
- Full and effective decentralisation of integrated services in water and sanitation
- Mechanisms for evaluating effectiveness and relevance of the interventions.

3.3.1 | ADOPTION OF THE MODEL AND SCALING-UP

In order to obtain a consistent model that would be relevant for use at nationa level, various steps had to be followed. Six critical steps were completed using active AMREF projects in other districts of eastern, central and northern Uganda Step 1 was applied to all districts while the rest of the steps were implemente in northern Uganda.

Step 1: Adoption of a universally accepted model at district and community level

Further consultations on a possible universally accepted model were made at selected sites across the country. These included Soroti in eastern Uganda Kawempe division (peri-urban settlement in Kampala hosting one of the larges slums) in central Uganda and Gulu, Kitgum and Pader in northern Uganda. The above model was also presented to the National Sanitation Working Group which deals with streamlining national policies and strategies. The model wa accepted as relevant and effective during all consultations.

On this basis, AMREF decided to use the model as a standard implementation approach in all its water and sanitation programmes. During the consultations sector policies and strategies were identified for review by the district core teams. The sector policies included the National Environmental Health Policy the National Water Policy, the School Health Policy, the National Gender Policy and the Memorandum of Understanding between MoH, MoWE and MoES While key strategies included Water and Sanitation Undertakings, the Kampala Declaration on Sanitation, the National Operation and Maintenance Strategy, the School Health Strategy, the 10 Year Integrated Sanitation and Hygiene Strategy (ISH), the National Sanitation Week and the National Hand-washing Strategy.

At the northern Uganda pre-test sites, a team of technical persons to implemen the intervention were named within the districts of Gulu, Kitgum and Pader. The teams agreed on representation, developed roles for each level and ensured these were consistent with sector policies and strategies. Further consultation were made at sub-county level with local leaders and extension worker to assess the relevance of the model and identify factors that would affec its implementation at community level. This resulted in a modified versio of the model that was used as a basis to streamline the water and sanitatio implementation process within the pre-test sites.

Step 2: Review and adoption of IEC materials

In order to review and adopt relevant IEC materials, core resource persons were identified by the district project implementation teams of Gulu, Kitgum, Amuru and Pader. They were divided into four working groups based on their interest and level of expertise. Each group was then asked to identify and review available IEC materials and generate capacity building packages in core areas including sanitation promotion, hygiene promotion, operation and maintenance (O&M) and community-based management information systems (CBMIS). They also developed a reference manual and corresponding curricula for training field extension workers based in the sub-counties. At least two workshops were held to review and adopt the knowledge products. In addition, teams of field extension workers from each of the pre-test sites were trained using the developed curricula.

Step 3: Developing training packages for community resource persons

For each working group a generic training package for training targeted community-own resource persons (CORPs) was prepared. Each package was developed to cover both theory and practical aspects of the components.

Step 4: Evaluating effectiveness of the capacity building packages

This was ensured in the following ways:

- Daily and end evaluation sessions by the trainees and joint review of the training process by the ToTs
- The working groups met quarterly to evaluate the effectiveness of interventions and identify areas of improvement
- Follow-up support supervision missions enabled the implementers to make comparisons between baseline and progressive conditions e.g., number of sanitation facilities built, level of utilisation and change in incidence of diseases.

Step 5: Incorporating participatory M&E into the packages

This involved the following steps:

- Monitoring indicators were identified at each level on the model. Core indicators that would be measured directly by the community were identified
- Terms of reference were prepared for regular meetings at each level. These were pre-tested for the respective target groups
- Reporting formats were reviewed and adopted
- A joint support supervision tool was developed and pre-tested at one of the pilot sites in Kitgum. This was adopted by both the district and sub-county teams

- Stakeholders at each level were oriented on the M&E framework, their role and agreed mechanisms for implementing the framework
- An integrated CBMIS system is being developed and will be linked texistin systems.

Step 6: Development and rollout of the CASHE tool kit

This will entail integration of the individual training packages (O&M, sanitation and hygiene) into a single tool kit. The tool kit will be presented both as an aid for community health workers (CHWs) and as an electronic package for use elsewhere.

3.3.2 | ACHIEVEMENTS

Model for implementing decentralised water and sanitation services adopted

A final model with a clear representation of roles and responsibilities was put in place. It clearly defines stakeholders at each level, their key relationships and role in implementing the key components (O&M, sanitation, hygiene and co-ordination).

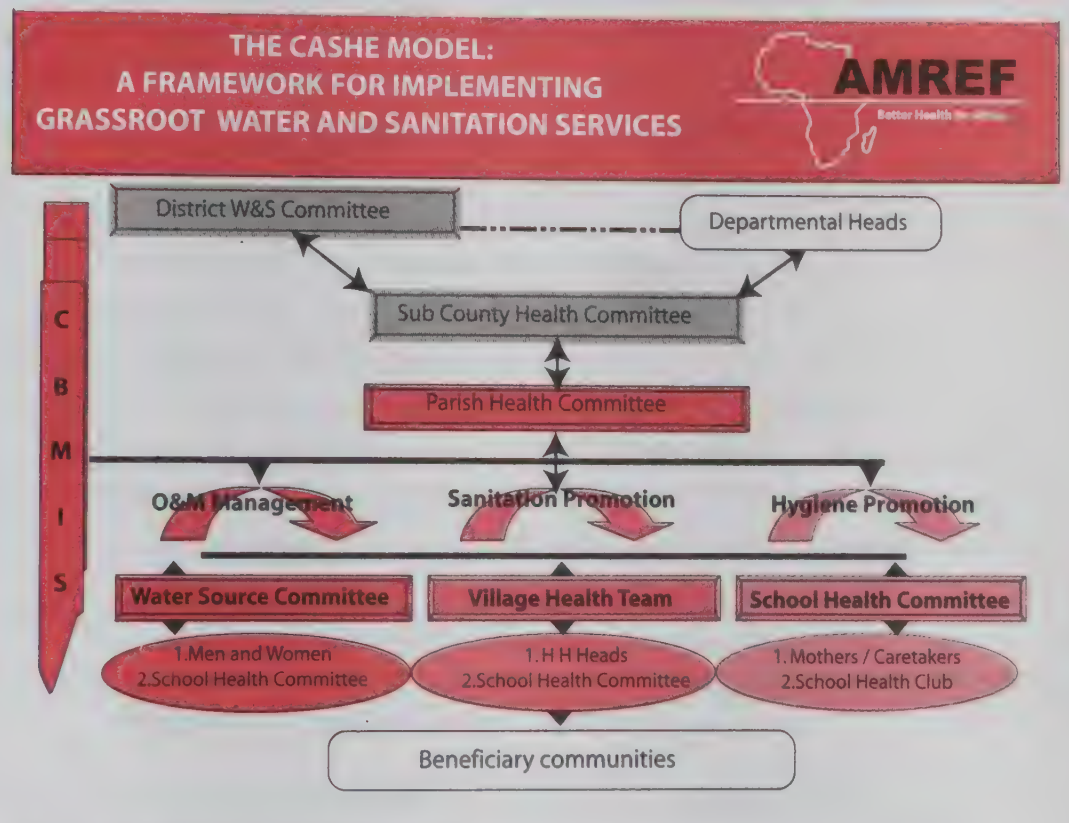


Fig 3.2: The revised and adopted model

Community-based communication aids developed for CORPs

Capacity building materials for sub-county-based field extension workers were developed (each with a curriculum and timetable) and included: a hygiene promotion manual for field extension; a sanitation promotion manual and an O&M manual for field extension workers. In addition, a set of communication tools for CORPs were developed and pre-tested. These are:

- Tools for use at household level by VHTs which include a poster of an ideal homestead showing different sanitation components and corresponding observable hygiene practices; flash cards showing different technological choices for latrines; fliers with basic messages on proper latrine use and maintenance; hand-washing, safe water chain management and safe food handling
- Tools for use at school level which include a poster of an ideal school

compound; a poster on personal hygiene practices to be observed b children and the PHASE tool kit to be used by teachers

- Tools for use at water sources by water source committees, which include poster of an ideal water source e.g., borehole, spring or standpipe; a cha showing water committee roles and responsibilities.

Procedure for establishing and strengthening a functional decentralised implementation system definec

The procedure for establishing implementation units at each local governme level entails a one-day meeting with stakeholders at each level to discuss th composition, roles and responsibilities, implementation plans and resource required. At the end of each meeting, a work plan is developed and specific role allocated to committee members. For example, at sub-county level all membe nominated to handle sanitation promotion in the sub-county health committe generic plan (Table 3.3) are trained as trainers in sanitation promotion by distri staff in a central workshop. They are equipped with skills and knowledge to trai lower level co-ordination units (PHCs, VHTs, WSCs and SHCs) to handle specif roles in sanitation promotion. Other generic plans produced would be for th PHC, VHT, SHC and WS

Table 3.3: Sub-county health committee generic plan

Sub-County Health Commitee Generic Plan 1: Approach to decentralize water and sanitation services at sub-county level										
ACTIVITY	MONTH 1				MONTH 2				Responsible Person	
									Leader	Support
1. BUILD CAPACITY OF TARGET GROUPS										
STEP 1: Sanitation promotion training									Judith A	Chairperson
STEP 2: Hygiene promotion training										
STEP 3: Operation and maintenance training										
STEP 4: CBMIS training										
2. SUPPORT IMPLEMENTATION OF PLANNED ACTIVITIES										
STEP 5: Launching of sanitation week										
STEP 6: Launching of hand washing campaign										
STEP 7: Inauguration of water users association										
STEP 8: Launching of a community-based management information system										
3. MONITORING AND EVALUATION										
PME 1: Organise monthly meetings for the committee										
PME 2: Collect data/maintain a records/submit reports										
PME 3: Participate in joint support supervision missions										
PME 4: Participate in parish health committee meetings										

Guidelines on effective work plan implementation developed

The generic plans suggest four core components that should be rolled out at community level:

(a) Sanitation promotion
(b) Hygiene promotion
(c) Management of operation and maintenance and
(d) Participatory monitoring and evaluation

The training aims to empower community-based groups with skills and knowledge to implement activities. The approach used for implementation of each of the components is described below.

The sanitation promotion approach

Step 1: Training of VHTs in sanitation promotion

Village health teams and representatives of the school health committee are trained and provided with IEC materials. The training covers various topics including basic sanitation, the main components of household sanitation, common sanitation practices, factors hindering improvement of sanitation in the community, current actors in sanitation promotion and their roles and the role of VHTs in sanitation promotion. Also covered are community-based management information systems and how to prepare sanitation improvement action plans.

Step 2: Mobilisation of household heads to improve sanitation

Trained VHTs are provided with communication and data collection tools (see Figures 3.3 and 3.4) to carry out a door-to-door sanitation education campaign targeting household heads and their spouses. At each household, the VHTs guide members to:

- Identify components of sanitation for an ideal homestead and their uses
- Identify existing facilities
- Prepare an action plan for upgrading existing facilities or including missing ones.

They then record data on existing conditions, planned sanitation improvements and common diseases among households with children under five years.

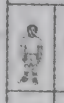
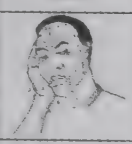
Fig 3.3: Tool used to educate household members on components of sanitation in an ideal homestead

Fig 3.4: Tool used to collect data on common diseases in the last two week among households with under five children

MORBIDITY REGISTRATION FORM

DISTRICT:..... COUNTY:..... SUB-COUNTY:..... PARISH:..... VILLAGE:.....

NAME OF VHT:..... No of HH:..... TOTAL POP'N SERVED:..... MALE:..... FEMALE:..... TOTAL:.....

HH NO.	IDENTIFICATION	AGE/GENDER				CAUSE OF SICKNESS IN THE LAST TWO(2) WEEKS					
		UNDER 5yrs		ABOVE 5yrs							
	NAME OF SICK PERSON										
		M	F	M	F						
	TOTAL										

Trained school health committees are also provided with communication and data collection tools (Figures 3.5 and 3.6) to enable them begin the process of sanitation promotion in schools. They begin by holding a school health committee meeting to:

- Update members on the role of a school health committee and agree on proposed responsibilities
- Review components of an ideal school compound and identify existing and missing sanitation facilities in the school
- Prepare an action plan for improving sanitation conditions in the school
- Discuss mechanisms for establishing a school health club and discuss its roles
- Agree on mechanisms for educating school children on household sanitation including appointing suitable teachers to carry out the education in each class.

Fig 3.5: Tool used by the school health committee members to review sanitation conditions, identify areas of improvement and prepare a school sanitation plan

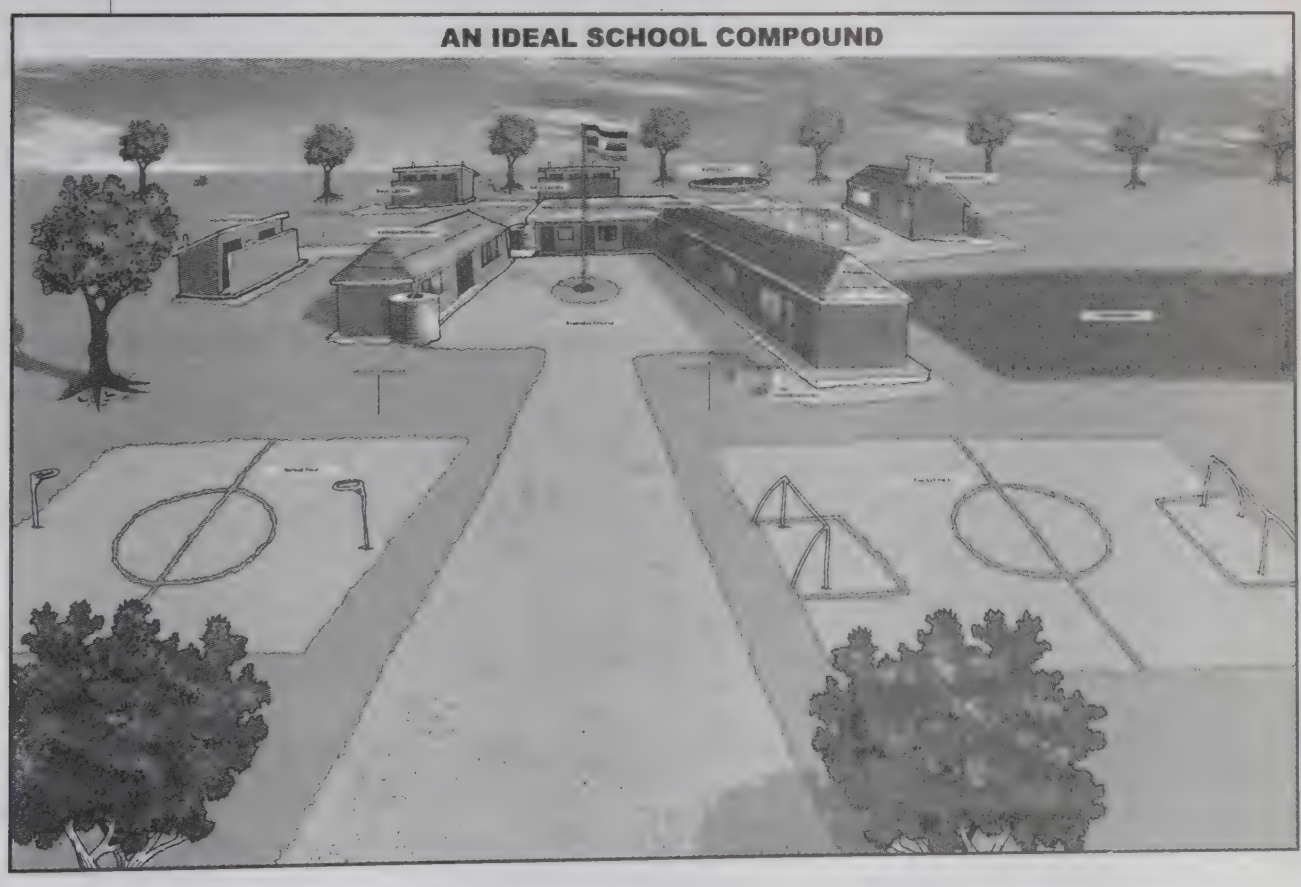
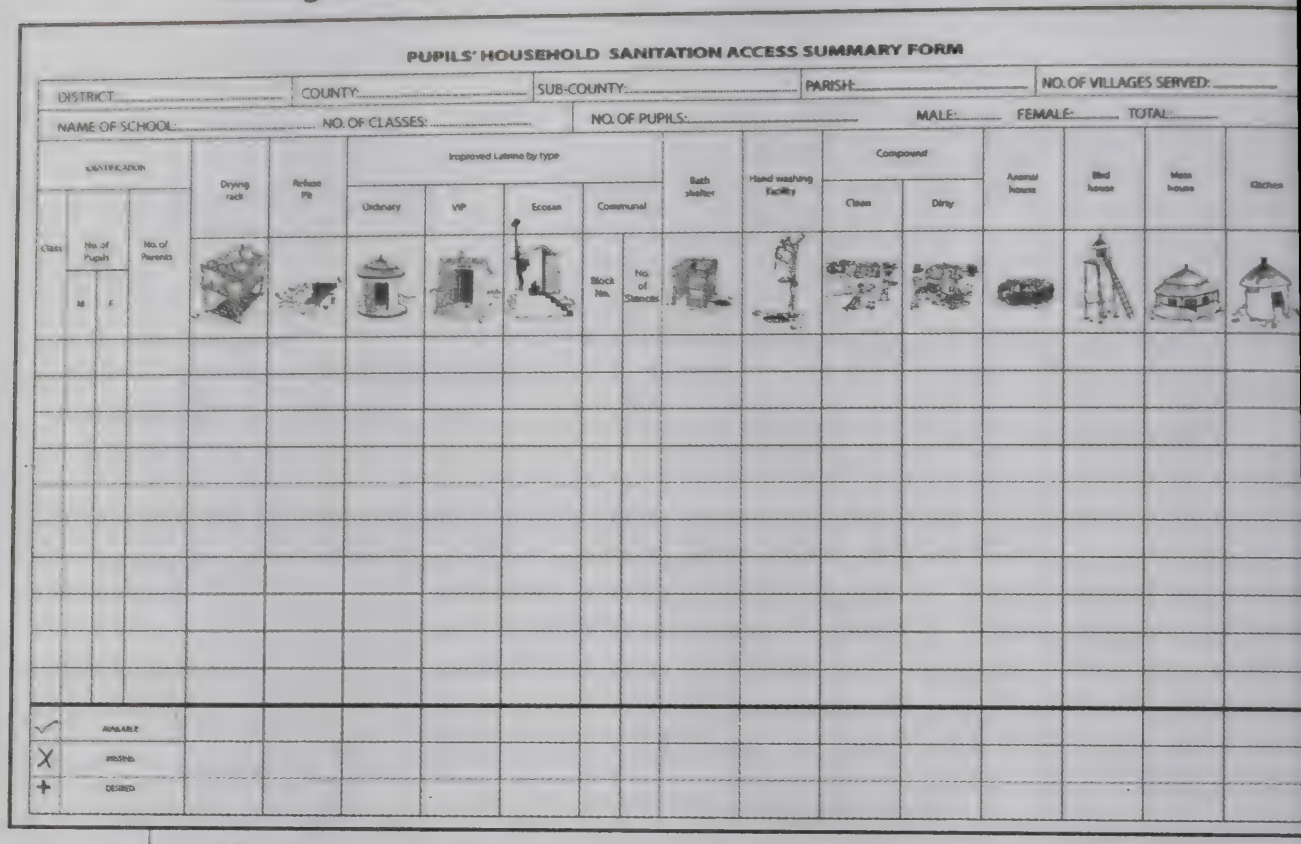


Fig 3.6: Tool used by school teachers to assess level of sanitation acces among children



PUPILS' HOUSEHOLD SANITATION ACCESS SUMMARY FORM

DISTRICT: ..... COUNTY: ..... SUB-COUNTY: ..... PARISH: ..... NO. OF VILLAGES SERVED: .....

NAME OF SCHOOL: ..... NO. OF CLASSES: ..... NO. OF PUPILS: ..... MALE: ..... FEMALE: ..... TOTAL: .....

IDENTIFICATION			Drying rack	Refuse Pit	Improved Latrine by type				Bath shelter	Hand washing Facility	Compound		Animal house	Bird house	Main house	Kitchen
					Ordinary	VIP	Ecosan	Communal								
Class	No. of Pupils M	No. of Pupils F	No. of Parents					Block No. / No. of Stances			Clean	Dirty				
✓	AVAILABLE															
X	MISSING															
+	DESIRED															

After the meeting, appointed teachers carry out classroom-based sanitation education and collect data on the present level of access and utilisation o sanitation facilities among children. This data is analysed for each class and village to obtain a picture of sanitation conditions in the communities. The teachers also begin collecting weekly information on the number of children absent and reasons for their absence.

Step 3: Planning meeting to prepare for the sanitation week campaign

The data collected is transferred into sanitation baseline and planning analysis sheets during the first parish meeting. From the analysis sheets the following is determined:

- Number of households planning to build new latrines in each village
- Time frame for completing the latrines
- Level of external support to enable households complete their plans
- Date for launching of the parish sanitation week.

Lists of households that will receive the sanitation kits are also prepared and launch sites identified. Influential persons to launch the sanitation week in each village are also identified. They include politicians, religious leaders, district heads of departments, opinion leaders and NGO staff. In addition, sanitation by-laws are reviewed and adopted for the first time.

A programme for launching the sanitation week should be developed with indicative costs and resource requirements, and roles and responsibilities agreed upon.

Step 4: Mobilisation of resources for launch of the sanitation week
During this period:

- Sensitization meetings in the target villages are held
- Date for the launch is determined and a programme drawn up
- Invitation letters are distributed
- Budgets are finalised
- Logistics for the event are completed – preparation of drama groups, launch venue, ground breaking sites, transport, public address systems, exhibition stalls etc.

Step 5: Launching of the parish sanitation campaign
Households that planned to build new latrines should be provided with sanitation kits during the launch. The objective is to provide a minimum of 10 kits per village and to ensure that these are used at least three times. Although the aim is to increase access to household latrines, household members are also encouraged to construct other sanitation facilities, a process which is achieved by identifying and marketing model homes (i.e. those that have a minimum of 80% of the facilities required to constitute an ideal homestead). School health clubs can play an instrumental role in setting up model homes especially in households with school going children. They should, therefore, be trained to construct simple sanitation facilities and begin by constructing these in their homes.

Step 6: Evaluating progress of implementation of planned activities
Parish health committee members should be trained on the basic concepts of monitoring and evaluation and reporting. Every week, tools for monitoring are distributed to VHTs through the parish health committees. Weekly monitoring meetings are held to check the progress of planned improvements and provide support to household members and VHTs.

An evaluation is carried out after three months to check the progress of implementation of planned activities and impact on morbidity patterns among children under five years and in school. All reports should be submitted to the sub-county health committee for review.

The hygiene promotion approach

The following steps are essential for developing capacity for management c community resource persons in hygiene promotion.

Step 1: Training peer educators in hygiene promotion

This should be conducted immediately after the launch of the sanitatio campaign. The participants are trained in promotion of hygiene targetin children of primary school going age and those under five years.

Step 2: Supporting dissemination of appropriate messages at households

- Hygiene promotion is carried out using the following approach:
- VHTs train parents of school children on proper latrine use and hanc washing
- Water user committees are formed and trained in safe water chain
- All female water committee members work with VHTs to promote safe foo handling and other practices
- School teachers promote the same practices through health clubs.

The process of disseminating appropriate messages involves identifying perso responsible for performing a particular behaviour within each household evaluating their level of performance (using a behaviour-specific monitorin form) and giving them correct messages on recommended hygiene practice Discussions are held to identify reasons for not performing certain behavio and agree on action required to achieve the desired behaviour. Examples of th communication tools used include:

- A flash card on recommended proper latrine use practices
- A flash card on safe food handling practices
- A flash card on safe water chain management practices
- A flash card showing the installation and use of a tippy tap near an improve latrine.

Fig 3.7: This tool is used by VHTs to educate caretakers on appropriate latrine use practices

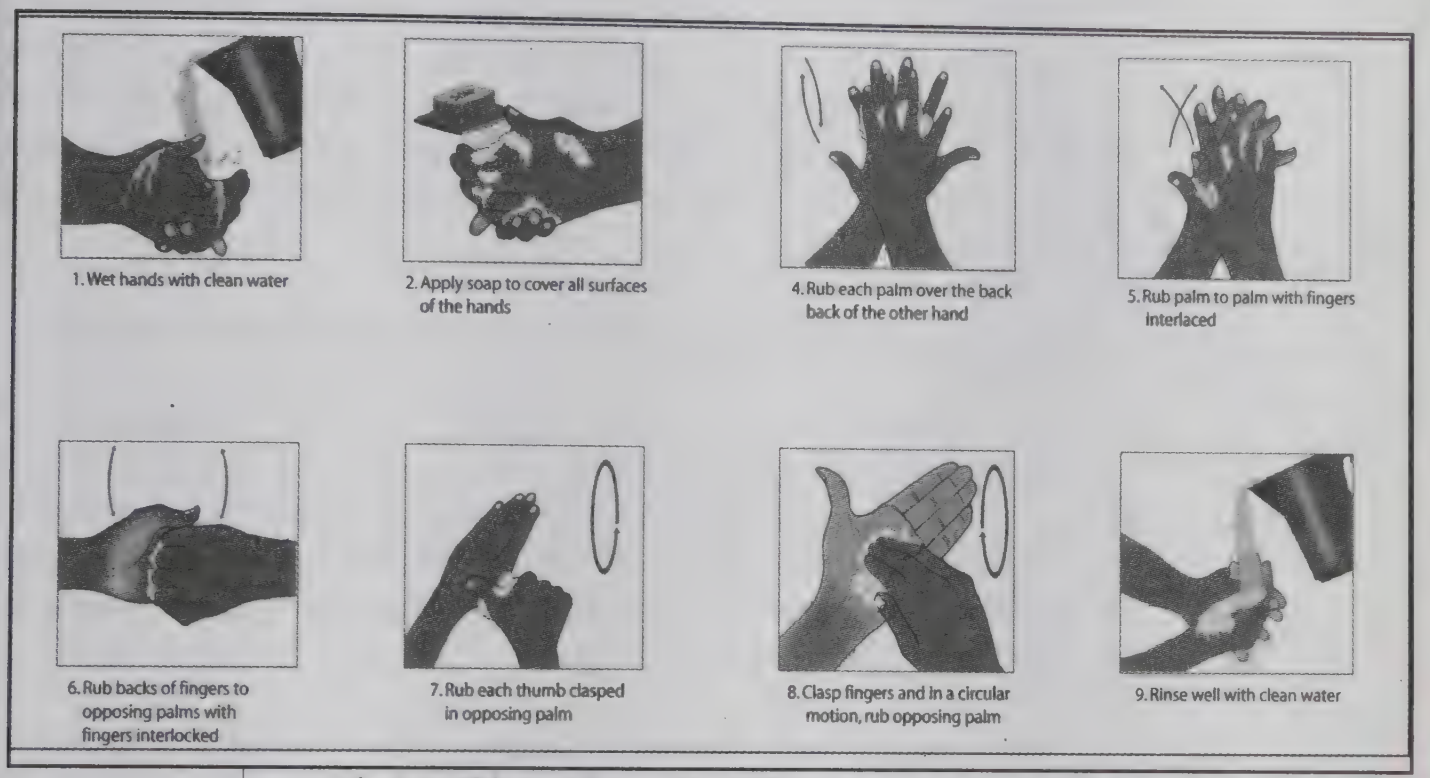


Fig 3.8: This tool is used by VHTs to promote use of an improved latrine that has a hand-washing facility and to encourage caretakers to teach children how to use the facilities

At school, dissemination of similar messages is done by teachers using th above communication tools during school assembly, classroom talks on relate topics in the PHASE manuals and through display of posters at strategic location e.g. classroom doors, toilet doors and latrine screen walls. The teachers als collect basic information on the level of access to basic sanitation and hygien facilities. Tools used include the sanitation access form, the hygiene knowledg assessment forms, components of an ideal school compound and the morbidit monitoring form.

Step 3: Supporting dissemination of safe hygiene practices through schools

A school health club should comprise four representatives from each class wh are potential peer educators and two teachers to guide the club's activitie Using data collected by peer hygiene educators and school teachers, member identify target groups, analyse the level of performance for specific practice identify key messages to be disseminated, potential methods of disseminatio and fora for disseminating the messages.

The members are also oriented on dissemination of messages through drama songs and poems. Techniques of follow-up through home visits (including th child to parent approach) should be reviewed and practised. A plan for th launch of the hand-washing campaign should also be agreed upon.

After the training, the school health committee supports school health clu members to develop drama on a key behavioural domain e.g., safe water cha management, while the parish health committee supports a similar communit group in a complementary key behavioural domain e.g., proper latrine use. Th two groups then perform during the launch of the hand-washing campaign.

Step 4: Planning and launching the hand-washing campaign

The drive to install hand-washing facilities should be launched through scho health clubs. The parish health committee should also plan for a mini-chi health day. Through the child-to-parent approach, parents who planned t install hand-washing facilities in their homes and to construct new latrines a given the necessary support. Small jerry cans are collected from parents, tipp taps made, hand-washing facilities installed in schools, and key messages o hand-washing disseminated. During the launch, flyers with instructions o hand-washing should be distributed.

Fig 3.9: Tool used by school children to request parents to build a latrine with adequate privacy and install a hand-washing facility near it

Step 5: Monitoring and evaluation

The entry point at this stage is training of parish health committee members as peer support supervisors. The training should enable the committee to prepare and implement a simple monitoring and evaluation plan using appropriate tools. Reporting requirements and procedures should also be reviewed. Weekly monitoring meetings are held to check progress on planned improvements, as well as to support household members and VHTs. Appropriate tools for monitoring hygiene behaviour change include:

- The hygiene co-ordination matrix for measuring process indicators and outputs
- The household hygiene monitoring tool to observe hygiene practices near sanitation facilities
- The school-based hygiene access tool for assessing perceived changes among children.

Fig 3.10: Tool for recording behaviour among school children

PUPILS' HYGIENE ACCESS SUMMARY FORM

DISTRICT:..... COUNTY:..... SUB-COUNTY:..... PARISH:..... NO. OF VILLAGES: .....

NAME OF SCHOOL: ..... NO. OF CLASSES: ..... NO. OF PUPILS:..... Male:..... Female:..... Total:.....

IDENTIFICATION			PROPER LATRINE USE	HAND WASHING WITH SOAP	BATHING REGULARLY	WASHING & DRYING UTENSILS ON DISH RACK	PROPER REFUSE DISPOSAL	SAFE STORAGE OF DRINKING WATER		SEPARATE DRINKING/ DRAWING CUPS	SAFE FOOD STORAGE
Class	No. of Pupils	No. of Caretakers						POT 	JERRYCAN 		
✓	ALWAYS										
X	NEVER										
+	SOMETIMES										

Guidelines for effective management of operation and maintenance

The following steps should be followed when developing the capacity of wate source committees to manage their facilities.

Step 1: Updating water user committee members at individual water sources

The parish health committee should use the Parish Operation and Maintenanc Status Form to collect data from each village on the type of water source number of households using the source, availability of water user committe members by gender and their current roles, number of beneficiaries and level o performance of committee.

Fig 3.11: A data collection tool used to record particulars of a water source

PARISH OPERATION AND MAINTENANCE STATUS FORM

Name of Sub County:..... Name of Parish:..... No. of Villages:.....

No. of Water Sources:BH....., SP....., SW....., TP....., VT....., RWT..... No. of Committe Members: M:..... F:..... Total:..... No. of HH..... No. of Users: M:..... F:..... Total:.....

Name of Water Source	Type	No of HH	No of Committee Members		No of Users		ACTIVITY STATUS									
			M	F	M	F										
Done ✓																
Not Done X																
Planned +																

This information is analysed and used to activate dormant water source committees to enable them start performing their roles. Each water source committee should be given an operation and maintenance review form to enable them allocate designated roles to specific members, a process which helps to identify trainees for operation and maintenance and also nominate those to carry out hygiene promotion.

Step 2: Establishing capacity for management of operation and maintenance at parish level

Selected members from each water source committee come together at parish level to be trained in the operation and maintenance of their water sources. Other members who may participate in the training include parish health committees and school teachers.

Step 3: Initiating water source committees to implement operation and maintenance plans

Individual water source committees are oriented on the components of an idea water source, roles and responsibilities of the water user committees, safe wate chain management and mechanisms for ensuring preventive and correctiv maintenance.

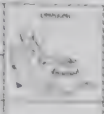
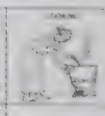
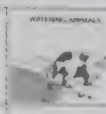
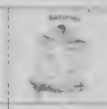
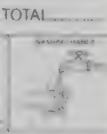
Fig 3.12: A communication tool used by the a caretaker to identify commo safe water chain practices at household level by checking in the apropriat box with a cross

Fig 3.13: A data collection tool used to record particulars of a water source

WATER USE MONITORING FORM

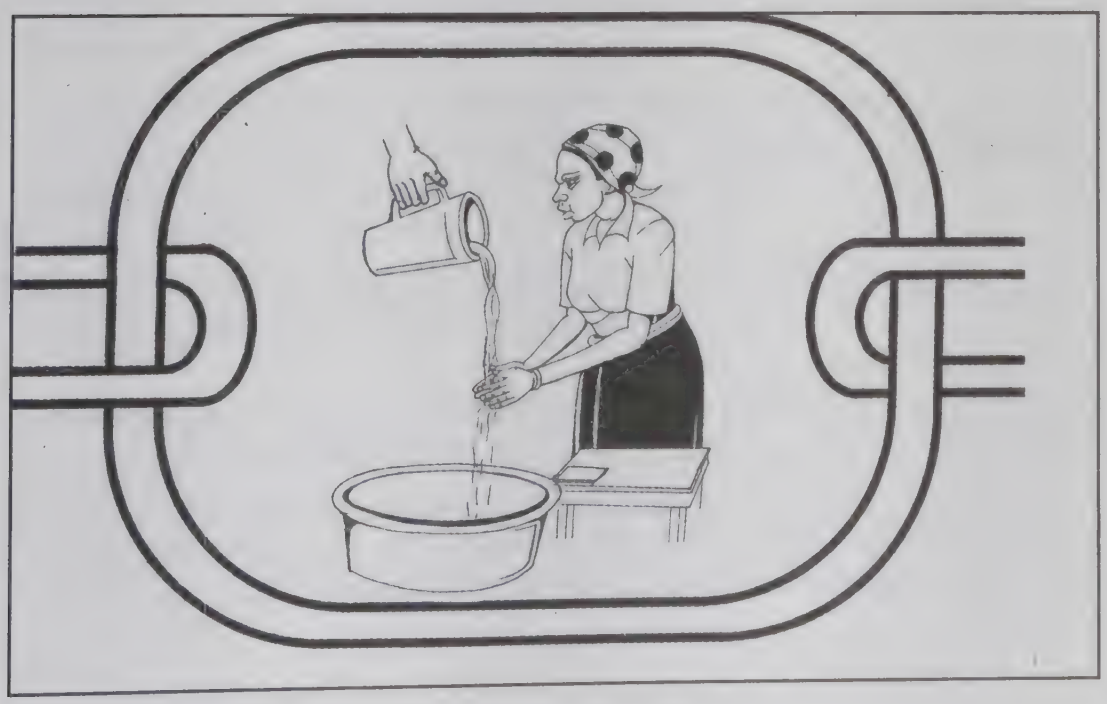
DISTRICT..... COUNTY..... SUB-COUNTY..... PARISH..... VILLAGE.....

NAME OF WATER SOURCE..... TYPE :BH.....SP.....SW:.....MOT:.....VT:.....RWT:.....GF:..... NO. OF USERS MALE..... FEMALE..... TOTAL.....

WSC No.	Name of Caretaker	No. of Users									
		M	F								

✓	Always
+	Sometimes
X	Never

Fig 3.14: This tool is used to emphasize the importance of cleaning the drinking water container and drying it on the rack to kill any pathogens



Step 4: Formation and training of a self help group (water users association)

At this stage a treasurer and chairperson from each water source meet at pari level to establish a self-help group. Other members include representatives fro the school health committee and VHTs. The group is affiliated to the parish hea committee and is responsible for management of operation and maintenan of water sources, school sanitation facilities and household sanitation facilit in their parish.

Step 5: Inauguration of the water users association

The self-help groups from various parishes then come together to establish sub-county water users' association. This association is trained on the self-he concept and given a basic start-up package during the launch at sub-coun level.

Step 6: Monitoring and evaluation

The entry point at this stage is training of the self-help group as peer suppo supervisors. The training enables the group to prepare and implement a simp monitoring and evaluation plan using appropriate tools. Reporting requiremer and procedures are also reviewed. Weekly monitoring meetings are held check progress on planned improvements and provide support to household members and VHTs.

Establishing a CBMIS component

Defining key components of a community-based health information system

A community-based management information system (CBMIS) is one whe communities collect, analyse, interpret and utilise the results for decisio making. Key components of a CBMIS include:

- An assortment of data collection and analysis tools in the core areas sanitation, hygiene and operation and maintenance
- Mechanisms for collecting data using the tools
- A time frame for collecting the data, analysing, dissemination and storage
- A simple format with selected indicators for disseminating data at commun level
- A clear system for storage of data collected and reporting to higher leve preferably one-stop centres for accessing information by all stakeholders
- A suitable database to analyse and store data electronically
- Fora for dissemination of information obtained e.g. regular parish meetin

Table 3.4: Assessing level of participation in current management information systems

LEVEL	Collection	Analysis	Dissemination	Utilisation	Storage	Updating
Ministry	√	√	√	√	√	√
District	√	√	√	√	√	√
County	√	Ø	√	√	√	√
Sub-county	√	Ø	x	Ø	√	√
Parish	Ø	x	x	x	Ø?	Ø
Community	Ø	x	x	x	Ø	Ø
VHT, WSC, SHC	Ø	x	x	x	√	Ø
Household	Ø	x	x	x	x	Ø

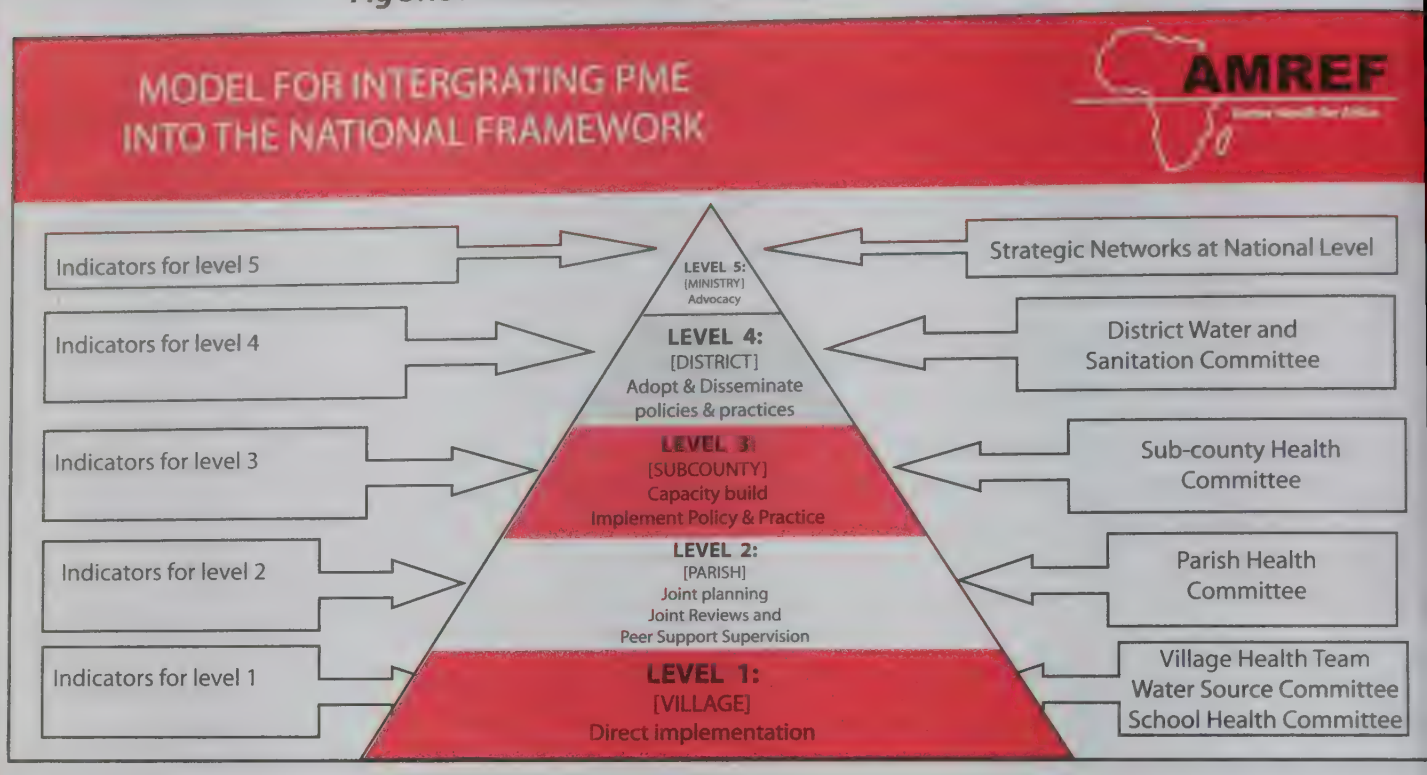
The above table can be used to evaluate information management at various levels within health systems of northern Uganda. The shaded area in the table depicts the level of influence of communities in information management. The table clearly shows that communities only participate (represented by Ø in the table) in collection and updating data. Most of the responsibilities for data management lie at district and ministry levels (represented with a √). The table also reveals limited participation (represented by an x) by communities in data analysis, dissemination and utilisation.

Since most diseases due to poor water and sanitation conditions are managed at community level, the corresponding indicative figures due to disease burden related to poor water and sanitation are deceptive.

Developing an M&E framework to be used to implement CBMIS

Incorporating CBMIS into a national HMIS requires identification of key indicators measured by relevant ministries at national level (e.g., the ten golden indicators to measure progress of water and sanitation). These are then assimilated at various levels, functions and representation. The model suggests different uses of the same indicators at different levels, which is a means of creating linkages.

Fig 3.15: A model for distributing indicators at different levels



Level 2 was used as an entry point for implementation of CBMIS. A framewo
for integrating indicators at different levels is shown below.

Fig 3.16: A template for an integrated M&E framework for WASH

An integrated M&E Framework for WASH

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Item	Key Indicators			MoV (Tool)	Source of data	Frequency	Responsible
	Sanitation	Hygiene	O&M				
Ministry							
District							
Subcounty							
Parish							
Village							

Reviewing tools used in collection and utilisation of information

To correct this anomaly, tools that could be used by community health workers to collect data on common diseases in the community were proposed. They include the mortality and morbidity tools, which were administered both in schools and within communities.

Fig 3.17: Tool used to assess the incidence of common diseases among school children

SCHOOL MORBIDITY REGISTRATION FORM

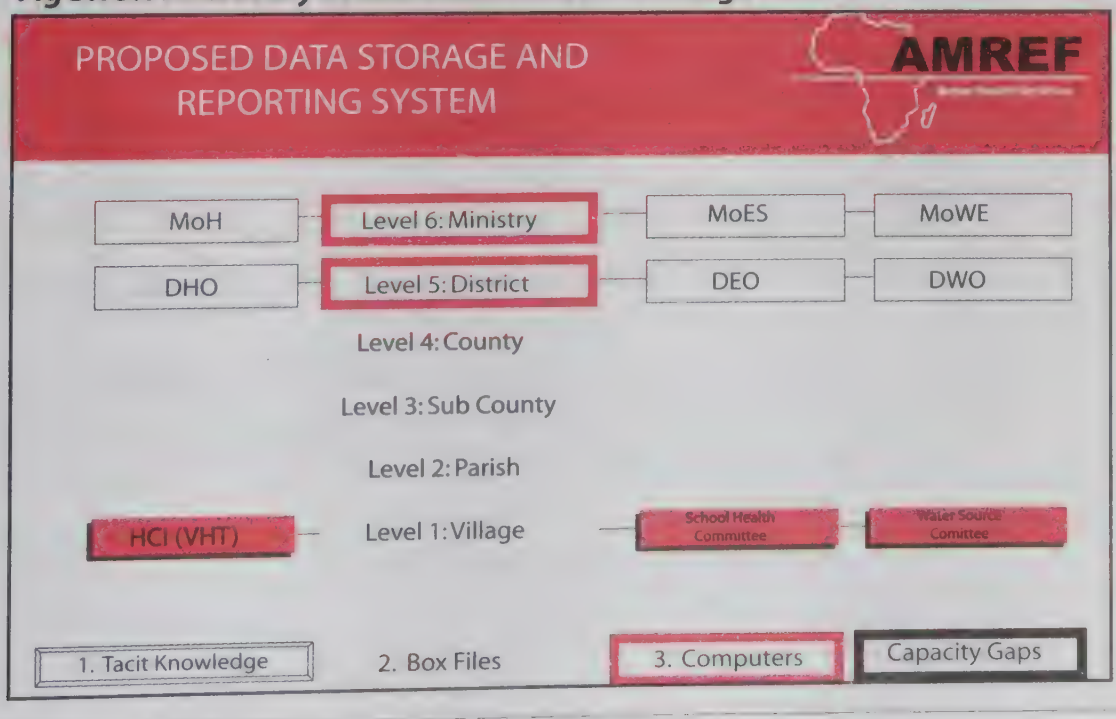
DISTRICT:..... COUNTY:..... SUB-COUNTY:..... PARISH:..... VILLAGE:.....

NAME OF SCHOOL:..... CLASS:..... NO. OF PUPILS:..... MALE:..... FEMALE:..... TOTAL:.....

HH NO	IDENTIFICATION	PARTICULARS				CAUSE OF SICKNESS IN THE LAST TWO(2) WEEKS					
	NAME OF SICK PUPIL	GENDER		CARETAKER		DIARRHOEA	EYE INFECTION	COUGH	FEVER	SKIN INFECTIONS	OTHER (SPECIFY)
		M	F	M	F						
	TOTAL										

Developing a data storage and reporting system

Fig 3.18: A hierarchy of data collection and storage centres



Box files are used as data collection units for lower levels while templates for electronic databases are being developed for incorporation into the HMIS systems.

Initiating an integrated approach to managing the community disease burden

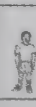
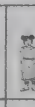
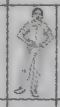
This approach recognizes that there are other health problems in the community other than those due to poor water and sanitation conditions. A tool for assessing and ranking the diseases can be used at baseline and evaluation stages to decide the next health problem to be addressed by the health committees.

Fig 3.19: Tool used to assess and rank common health problems in the community

HOUSEHOLD HEALTH STATUS FORM

DISTRICT:.....	COUNTY:.....	SUB-COUNTY:.....	PARISH:.....	VILLAGE:.....

NAME OF VHT:..... NO OF HH:..... TOTAL POP'N SERVED:..... MALE:..... FEMALE:..... TOTAL:.....

HH NO.	IDENTIFICATION	Number of Persons in Household				MAJOR HEALTH PROBLEM IN THIS FAMILY IN THE LAST SIX(6) MONTHS					
		UNDER 5yrs		ABOVE 5yrs		DIARRHOEA	MALARIA	TUBERCULOSIS	HIV/AIDS	TYPHOID	OTHER (SPECIFY)
	NAME OF HH HEAD										
		M	F	M	F						
	TOTAL										

If water and sanitation related health problems have been effectively addressed, then the parish health committee embarks on addressing other health problems on the basis of results obtained.

3.3.3 | PROJECT IMPACT

In Madi-Opei sub-county, a pilot site for sanitation promotion, AMREF supported activities of extension workers in Okol and Pobura parishes where VHTs were trained in effective sanitation promotion. After the training, they were given communication tools which they used to educate household heads and their spouses on basic components of sanitation and collected data on existing sanitation facilities and on what the household members wished to have as new sanitation facilities (household action plan). The VHTs were assisted to analyse and interpret data collected, which they used to prepare a parish sanitation improvement plan. At Okol parish, AMREF also facilitated the launching of sanitation week on 6th May 2008, during which 180 sanitation kits were distributed by district leaders to households that had expressed the desire to have their own latrines.

A follow-up joint support supervision (SS) mission was conducted at the end of the agreed construction period, in June 2008. Results of the SS in the Sanitation Improvement Chart (Figure 3.20) indicates that Ordinary Pit Latrine (OPL) coverage at the return sites had improved from 4% at the beginning of May 2008 (when the parish sanitation campaign was launched) to 62% at the end of June 2008. This performance already exceeded the measured expressed demand. Other household sanitation facilities that had similar performance over the same period include main house (MH), hand-washing facility (HWF), dish drying racks (DR) and bath shelters (BS).

Fig 3.20: Sanitation Performance Chart

Terminology	***Explanation***
Baseline	*Information obtained before intervention*
Expressed Demand	*A measure of desire by households to improve sanitation facilities*
SS Coverage	*Coverage obtained during joint support supervision missions*

Early results suggest a similar increase of sanitation facilities in Pobura parish where AMREF supported training of another group of VHTs in June 2008. Here the number of household latrines already in use increased remarkably from three existing (1.8%) to 32 (19%) within a space of one month! In addition, another 69 (42%) are under construction, which will improve the result for latrine coverage to 61%. Within other non-AMREF intervention return sites in the sub-county, the number of latrines dug over the period has remained relatively low.

(Figure 3.21) shows results of observed hygiene behaviour for existing facilities at households. The chart was derived from information gathered during a joint support supervision mission by the parish health committee of Okol in Kitgum district.

Fig 3.21: Hygiene Performance Chart

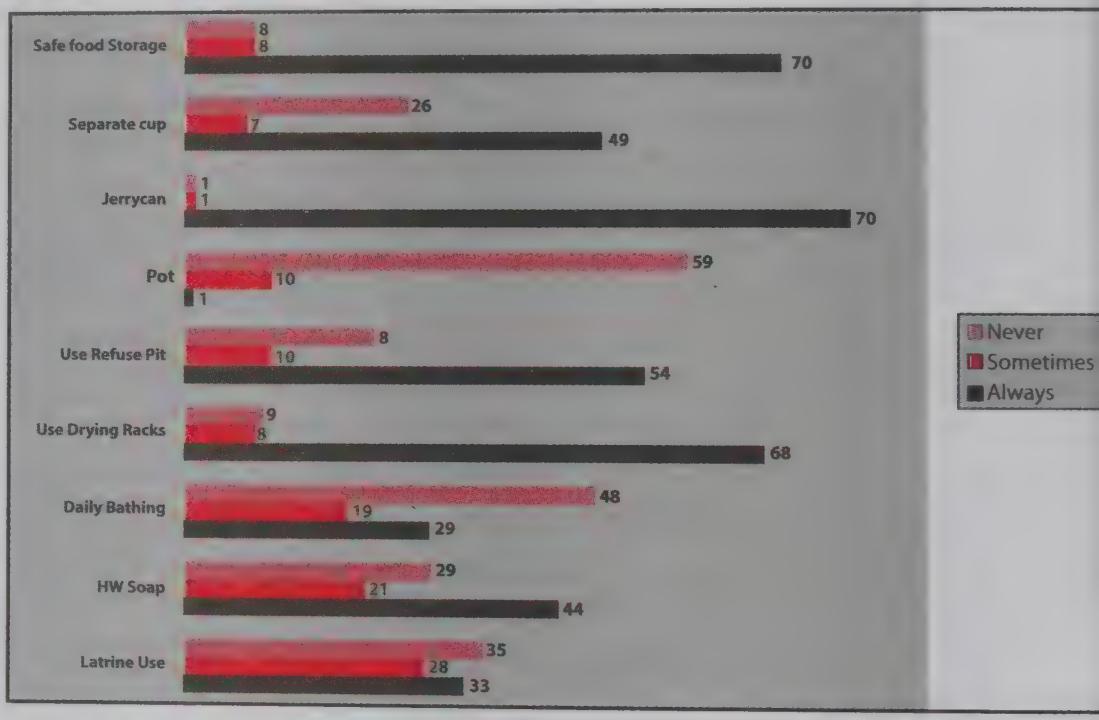


Table 3.5 attempts to compare data on availability of facilities and level o utilisation (using the sanitation and hygiene improvement charts above) i order to determine the proportion of households that still need to be targeted for behaviour change.

It reveals that interventions on safe water chain management and safe food handling were successful. However, although there is a relatively high coverage of household latrines (62%) and hand-washing facilities (78%), performance levels related to proper latrine use (33% always) and hand-washing with soap (44% always) still need further action if satisfactory utilisation rates are to be achieved. The table reveals that the thrust of hygiene promotion in Okol Parish should focus on proper latrine use, hand-washing with soap/ash and persona hygiene.

Table 3.5: Availability of facilities and level of utilisation

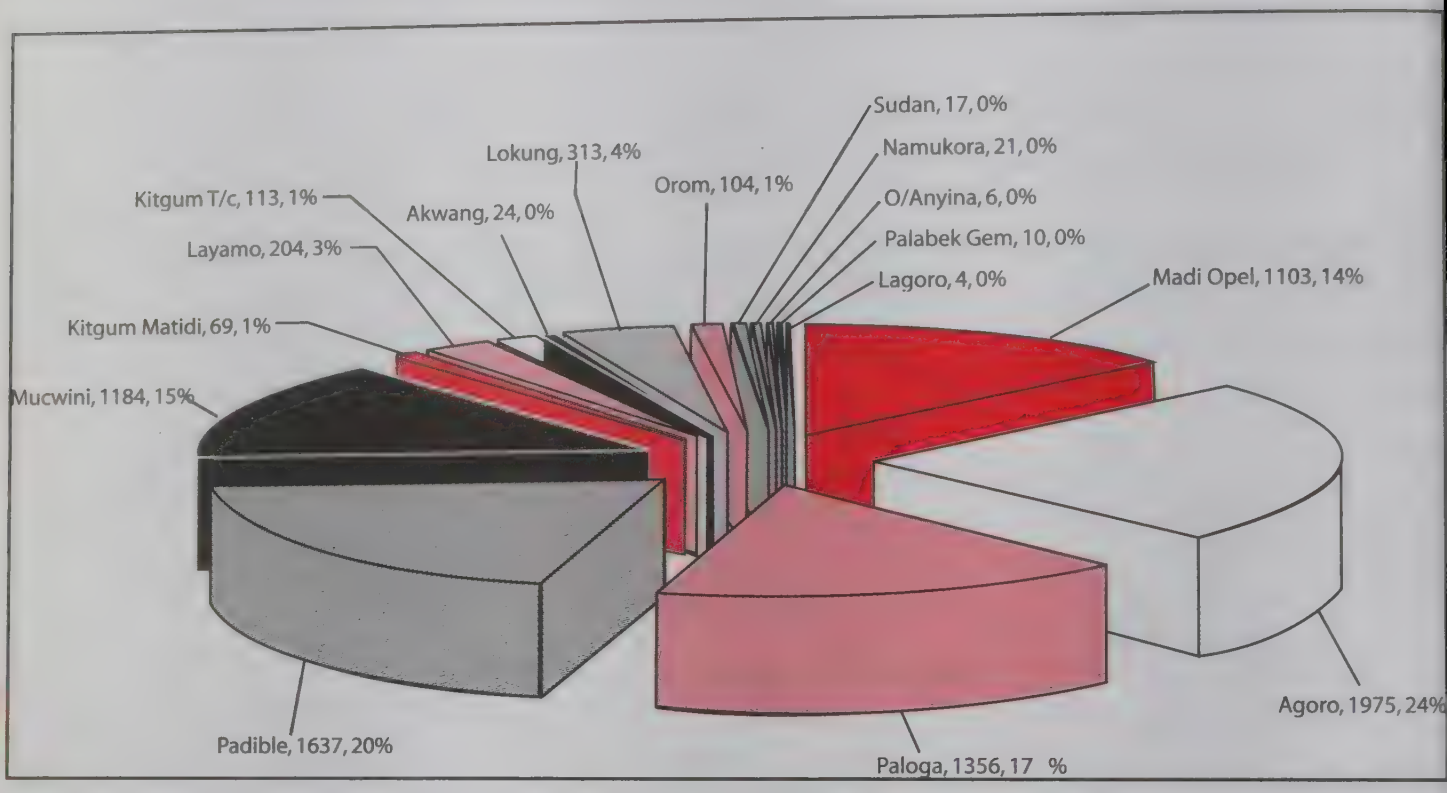
Sanitation facility	HH coverage	Level of Utilisation			Behaviour Change	Target Ranking
		Always	Sometimes	Never		
Dish rack	88%	68%	8%	9%	17%	6
Hand-washing facility	78%	44%	21%	29%	50%	4
Bath shelter	47%	29%	19%	48%	67%	1
Ordinarypit latrine	62%	33%	28%	35%	63%	2
Refuse pit	65%	54%	10%	22%	32%	5
Separate cup for drinking	78%	49%	7%	44%	51%	3

Degree of cost effectiveness of intervention

An integrated approach to sanitation, hygiene and operation and maintenance is cost effective as it brings benefits of improved sanitation, hygiene and sustainable water supply at the same time. The approach promotes equitable investment in sanitation and hygiene and optimizes utilisation of available community resources.

A good example is the intervention approach to combat Hepatitis in Madi-Opei sub-county, which enabled communities in Okol parish to take a lead in constructing their own sanitation facilities within the expected timeframe, and are now utilising them. Whereas AMREF promoted sanitation through village health teams, other organisations such as OXFAM and WHO promoted appropriate hygiene practices. So far a total of over 4800 cases of Hepatitis E (a faecal-oral disease mainly spread due to poor sanitation and hygiene conditions) have been reported and 72 deaths registered. The virus has already spread to 12 out of the 19 sub-counties in the district and even crossed borders to Gulu and Pader districts. However, within Madi-Opei Sub-county, the weekly incidence rate of Hepatitis E begun decreasing sharply soon after the sanitation week campaign was launched. But at the return sites, where AMREF intervention were pre-tested, new cases have remained extremely low compared to the main camps and other parishes within the sub-county that are non-intervention sites.

Fig 3.22: Hepatitis E burden by sub-county as at 15th Sept 2008



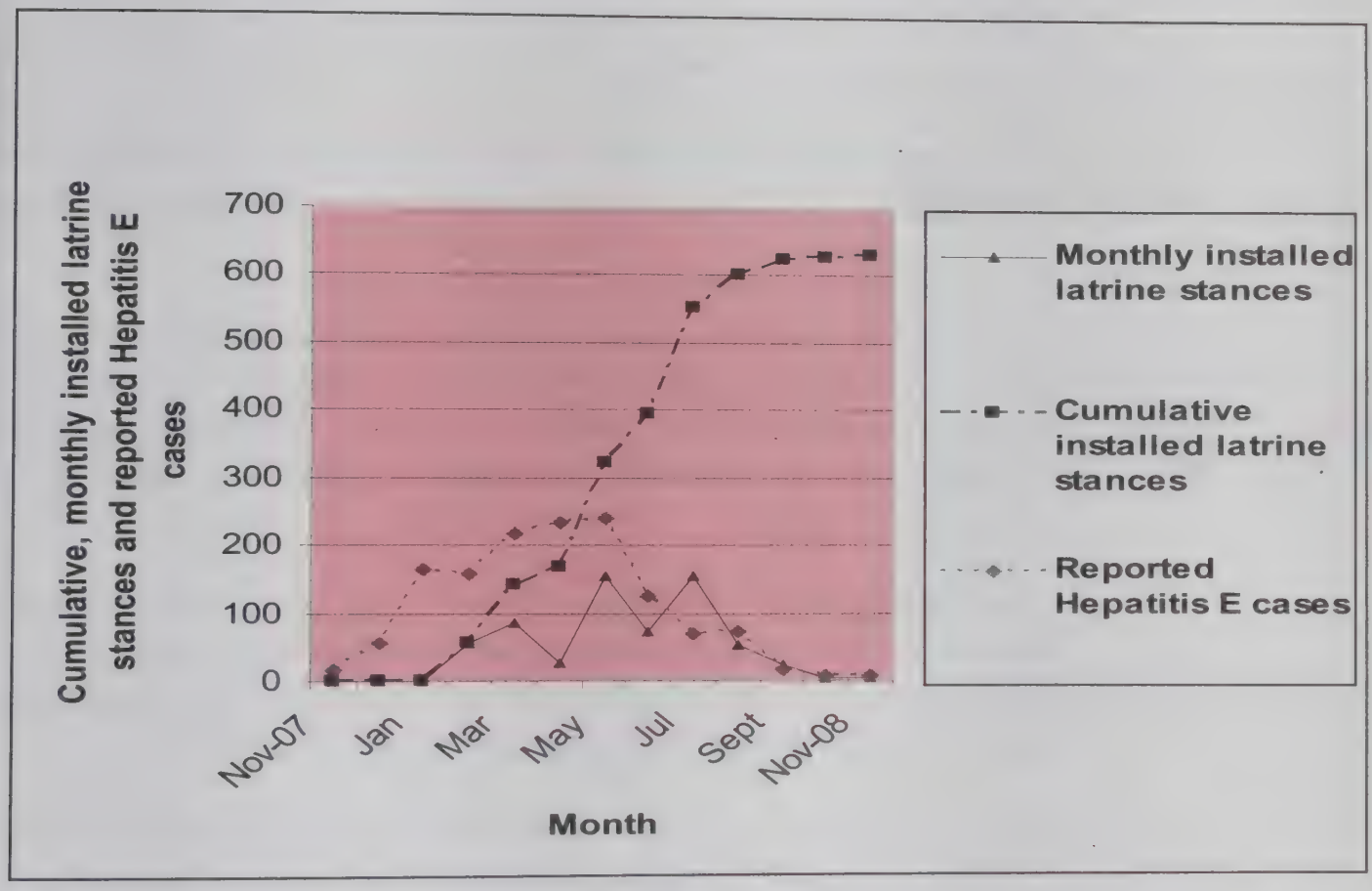
Source: WHO Kitgum

Figure 3.22 shows the hepatitis E burden per sub-county. The most affected sub-counties are Agoro (24%), Padibe (20%), Paloga (17%), Madi Opei (14%) and Mucwini (15%) respectively.

The weekly incidence curve of Madi Opei as seen in Figure 3.23 shows a decreasing trend of hepatitis E cases in the sub-county against the number of latrines dug.

The graph shows that the trend of hepatitis E started declining when the cumulative number of installed latrines in use exceeded 200, declining to zero

Fig 3.23: Variation of monthly and cumulative installed latrine stances against reported Hepatitis E cases



when this number tripled. It should be noted that humanitarian actors left this sub-county to operate on its own as they continued to fight the epidemic of other affected sub-counties. The communities in the target villages have started implementing model villages.

However, operation and maintenance was not incorporated into the intervention approach and this was pointed out as a need by the parish health committee. In addition, a lack of an O&M component affected the level of ownership and utilisation, especially of the latrines and hand-washing facilities. In other non-AMREF intervention sites, ownership and utilisation of constructed facilities is one of the major constraints to sanitation promotion.

3.3.4 | CHALLENGES

Although the CASHE model is an effective tool for decentralising water and sanitation services, a lot of work still needs to done to enable scale-up in non intervention areas. Different implementation strategies by agencies disrup piloting of new models and approaches and are a major obstacle to rolling ou the CASHE model.

The sequencing of intervention activities was not well co-ordinated a community level and at times duplication of efforts was reported. Because o a strong inclination by other agencies towards an emergency response, it wa difficult to establish the community-based system on the basis of the CASH model. The time frame for implementation of activities could have been shorte if the sequencing of activities and corresponding flow of resources was adhere to.

It has not been possible to produce an integrated package that can be use to assess efficiency of interventions. This is because the development of th packages was done in phases with sanitation coming first, hygiene second, O&M third and CBMIS last. This vertical approach to implementation is also commo among district partners and other organisations.

Government policy of restricting communities to pay user fees needs to be lifte in the wake of returning communities due to the prevailing peace conditions i northern Uganda. This is because most communities leave the responsibility o operation and maintenance to trained water user committees.

Government extension workers need adequate logistical support (especiall in terms of transport and fuel) to enable them carry out the duties an responsibilities effectively.

3.3.5 | LESSONS LEARNT

- Involving community resource persons to develop their own IEC materials ensures relevance and effectiveness of the materials to the target groups
- Hygiene promotion without improved sanitation is not cost effective
- Hygiene behaviour is related to fundamental issues about cleanliness that are inculcated and absorbed at a very early stage among young children. Therefore, this aspect needs to be targeted through mothers and teachers
- Data collection tools with visuals stimulate community participation and action
- Engaging household heads and their spouses results in quality action plans and sustainable improvements in sanitation and hygiene
- The concept of operation and maintenance should not only be limited to water sources. It should also cover sanitation facilities in schools and households
- Community partnerships are vital for active engagement in mobilising and supporting sanitation and hygiene promotion interventions
- For achievements to be realised, key decision makers – governments, communities, NGOs and private sector collaborators need to work together to support a single clearly defined service delivery system.

3.3.6 | CONCLUSION AND RECOMMENDATIONS

The CASHE model defines critical partnerships that constitute a system with which to implement water and sanitation policies, strategies and services. Co elements that have to be implemented within this system include sanitatio hygiene, operation and maintenance and CBMIS.

Community health workers, when equipped with the necessary skills an knowledge, are effective in delivery of water and sanitation policies an programmes. They should be provided with communication tools for carryin out door-to-door education, assisting households to engage in plannin for improvements and recording information on existing conditions an improvements. Information collected by health workers should be analyse interpreted and disseminated in a timely manner and used for decisio making.

The capacity of community health workers can further be enhanced b strengthening support structures at higher levels to enable them meet regular to share experiences and improve on their knowledge and skills. A lot of effo is required to change the service providers from traditional capacity buildin methods to this new approach. Although capacity building manuals exist, mo of these have been developed at higher levels and are not easily understood b field extension workers. There is, therefore, need to encourage use of simplifie manuals in water and sanitation, preferably those in which they have bee involved in developing.

The concept of using generic work plans to allocate roles and responsibilities new but appears efficient and presents many benefits. It promotes performanc based capacity building programmes that maximise on giving trainees targete knowledge and skills, while allowing planners to manage related co-ordinatio and collaborative aspects. It also helps to link specific activities for monitorin by community health workers.

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4

BUILDING COMMUNITY CAPACITY IN HIV/AIDS RESPONSE: THE CASE OF MAANISHA PROJECT

By
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ABBREVIATIONS

AEO	Agricultural Extension Officer
AIDS	Acquired Immune Deficiency Syndrome
AMPATH	Academic Model for Prevention and Treatment of HIV/AIDS
AMREF	African Medical and Research Foundation
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CACC	Constituency AIDS Control Committee
CBS	Central Bureau of Statistics
CCC	Comprehensive Care Centre
CHW	Community Health Worker
CSO	Civil Socitey Organisation
CSW	Commercial Sex Worker
DDO	District Development Officer
DfID	Department for International Development
DHS	Demographic and Health Survey
DTC	District Technical Committee
FBO	Faith Based Organisation
GAC	Grants Approval Committee
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
GOK	Government of Kenya
HBC	Home Based Care
HEDC	Health & Economics Development Consortium Group
HIV	Human Immuno Deficiency Virus
IDU	Injecting Drug Users
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
MARP	Most At-Risk Population
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NGO	Non-Governmental Organisation

NHSSP	National Health Sector Strategic Plan 1
ODSS	Organisational Development and Systems Strengthening
PLHIV	People Living with HIV
PSO	Private Sector Organisation
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
TOWA	Total War on AIDS
TRC	Technical Review Committee
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
USD	United States Dollar
VCT	Voluntary Counselling and Testing
WAFNET	Women Action Forum for Networking
WB	World Bank
WHO	World Health Organisation

ABSTRACT

This case study documents the experiences drawn from AMREF's Maanisha programme in Kenya which works with various stakeholders for a co-ordinated and participatory HIV/AIDS response. The programme applies a twin approach of provision of capacity building and grant making. The study highlights the lessons learnt in contributing to a co-ordinated, harmonised, participatory and vibrant response to HIV/AIDS in Kenya. It draws a number of recommendations for future policy and practices based on the programme's experience.

ACKNOWLEDGEMENTS

We would like to thank Dr. Thomas Kibua, AMREF's Director of Health Policy an Systems Research for providing guidance and mentorship during the compilatio of this case study. We would also like to acknowledge the contributions of th following members of the Maanisha team: Nelson Otwoma, Dr. Njeri Mwaura Alison Gichohi, Fred Ogolla, Ignatius Mutula and Naomi Mwangi.

We are grateful to: Mette Kjaer, Country Director, AMREF in Kenya; Dr. Festu Ilako, Deputy Country Director and Head of Programmes; Dr. David Ojaka Programme Manager, HIV/AIDS and Health Systems Research; Josepha Nyagero, Programme Manager, Research for reviewing the paper, and Bett Rabar for editing the document.

We are also thankful to the Swedish International Development Co-operatio Agency (Sida) and the Department for International Development (DfID) UK fo providing the financial assistance to implement the programme.

4.1 | INTRODUCTION

By the end of 2007, close to 33 million people were living with HIV globally (UNAIDS, 2008). During the year, a total of 2.7 million people were newly infected with HIV and the AIDS epidemic had killed 2.1 million people. Over two-thirds of people living with HIV (PLHIV) are from sub-Saharan Africa. The region accounts for almost three-quarters of all AIDS-related deaths globally. In sub-Saharan Africa the epidemic is characterised by marked gender inequalities with 59% of PLHIV being female.

Since its formation in 1999, Kenya's National AIDS Control Council (NACC) has co-ordinated the country's HIV/AIDS response. It has led in the formulation and implementation of two national AIDS strategic plans for the periods 2000-2005 and 2005-2010. The current strategic plan provides the overall direction for HIV/AIDS programming in Kenya and advocates for a multi-sectoral and comprehensive approach encompassing prevention, care, treatment and support, and socio-economic mitigation (NACC, 2005). Through NACC's leadership, Kenya's HIV/AIDS response has evolved in both geographic and conceptual terms. Conceptually, the country has progressed from managing HIV and AIDS as a medical problem, to recognising the public health significance of the epidemic, and today applies a social model to HIV/AIDS programming. Key stakeholders in Kenya recognise that the pandemic has enormous negative social and economic effects and can only be effectively addressed through a multi-sectoral response based on partnerships among stakeholders. This shift has led to considerable changes in HIV/AIDS programming including a shift from largely health facility-based activities to a greater balance between health facility and community-based interventions. There is greater involvement of communities including beneficiaries, civil society and private sector. However, gaps abound regarding optimal approaches for co-ordinating and harmonising the response while fostering genuine involvement and empowerment of communities.

4.2 | LITERATURE REVIEW

Kenya has been grappling with the HIV/AIDS pandemic for the last three decades. The country is among the high HIV and AIDS burden nations with prevalence above 5% since 1990. For instance, the prevalence of HIV among adults aged 15-49 years has risen from 5.3% in 1990 to 7.4% in 2007 translating to more than 1.4 million PLHIV (NASCOP MOH, 2008). In addition, the epidemic is marked by considerable gender and geographic disparities. Five females are infected with HIV for every three males infected in the 15-64 years age bracket (*Ibid*). This feminisation of HIV is an established pattern since the 1990s and has been attributed to interplay of physiological susceptibility and power relations (Longfield et al, 2002).

Out of the country's eight administrative provinces, two have prevalence well above the national average with Nyanza province leading at 15.3% followed by Nairobi at 9% (NASCOP MOH, 2008). In 2006, 140,000 people died due to AIDS leaving a cumulative total of 1.1 million orphans aged 0-17 years in Kenya (NACC 2007). Worse still there are about 150,000 children aged 0-14 years living with HIV. The country has witnessed a decline in life expectancy from 61.9 years in the period 1979-1989 to 56.6 years in the period 1989-1999, and to 50.5 years in 2006 (CBS, 2002; NACC, 2007). The low life expectancy is largely attributed to the interplay between HIV/AIDS and poverty. Poverty is prevalent, with over half of the population (56%) surviving on less than 1US$ a day (CBS, et al., 2004).

An assessment undertaken by AMREF (2004) in the Lake Victoria Basin region of Kenya and baseline assessment undertaken one year later (AMREF, 2005) revealed that the country's HIV/AIDS response was hampered by constraints in five areas namely:

- Co-ordination
- Communities' capacity
- Participation of communities in HIV/AIDS mitigation
- Availability of resources to communities
- Challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most-at-risk[1] categories of Kenya's population.

These findings corroborate those found in other assessments of Kenya's past national response to HIV/AIDS *(Delion et al, 2004)*.

In the last decade, the fight against HIV/AIDS in Kenya has gotten more funds and commitment from the government, Global Fund to fight Tuberculosis AIDS and Malaria (GFTAM), the World Bank, bilateral donors, and private sector foundations. However, the increase in the number of actors at both country and local levels has resulted in vertical and piecemeal interventions that are

1. *Most-at-risk populations include people living with HIV, widows, youth, sex workers, men who have sex with men, injecting drug users, a people with disabilities.*

unsustainable. The efforts require greater co-ordination among partners to ensure that resources are not wasted and actions are not duplicated – thus the need for application of the "Three Ones" principles[2] . Although Kenya is a signatory to the principle, findings from the assessment undertaken by AMREF revealed that a third of CSOs were not following the national guidelines in HIV/AIDS implementation (AMREF, 2004). Further, many rarely reported to NACC nor used the harmonised HIV/AIDS indicators stipulated in the national monitoring and evaluation framework. The co-ordination of HIV/AIDS response in Nyanza and Western provinces was weak with district NACC structures citing duplication of roles, inadequacy of resources to facilitate co-ordination, and low monitoring and evaluation capacity.

On the other hand, the capacities of communities to mount an effective response were weak (AMREF, 2004). In Kenya, organised communities such as local CSOs have tried to address local needs including those that have arisen as a result of HIV infections. While the emergence of these groupings ought to provide the continuity and long-term commitment required for sustainable development, many CSOs did not have the organisational and technical capacities needed for designing, implementing, and monitoring effective HIV and AIDS interventions. For instance, among 70 CSOs surveyed, only 20% had elected leaders, 15% had annual plans to guide implementation, 53% had financial procedures in place, 22% used finances efficiently, and 68% had a constitution *(Ibid)*. The CSOs lacked systems of tracking their performance and resource utilisation, a situation that made it difficult to assess the efficiency and effectiveness of community interventions. Without adequate organisational capacity, the CSOs could not efficiently use any technical skills they possessed. These co-ordination and harmonisation gaps had also been recognised as key challenges during implementation of the World Bank-supported Kenya HIV/AIDS Disaster Response Project that was part of the Multi-Country AIDS Programme (Delion *et al*, 2004). Effective HIV/AIDS programming calls for adequate co-ordination by NACC at all levels coupled with participation and empowerment of communities.

Equally, linkages between the CSOs and government structures were very weak and were characterised by a palpable disconnect between what the CSOs were doing and what the formal health system desired (AMREF, 2004). It was difficult for CSOs to implement HIV and AIDS interventions in line with government policies and guidelines simply because they did not have the information. For example, while Kenya's Ministry of Health curriculum on home and community-based care training recommends a training duration of 11 days, many CSOs conducted such courses for a period of about three days (AMREF, 2004). Further,

2. On 25 April 2004, UNAIDS, and other stakeholders co-hosted a Consultation on Harmonization of International AIDS Funding and formally endorsed the "Three Ones" principles, which call for the following components as it relates of HIV and AIDS Programming: (a) One agreed AIDS action framework that provides the basis for co-ordinating the work of all partners, (b) One national AIDS co-ordinating authority with a broad based multi-sectoral mandate; (c) One agreed country-level monitoring and evaluation system.

the CSOs did not know what support to expect from district NACC and Ministry o Health structures because the structures rarely involved the CSOs in local reviev and planning processes. Notably, the relationship between NACC structures and the CSOs was characterised by mistrust. These weaknesses worsened the co ordination and capacity gaps described earlier. In order to promote sustainabl health development, communities should be proactive participants in an health system designed to serve them (AMREF, 2007b).

Further, massive funding gaps among CSOs in Kenya undermined effective HIV AIDS responses (Delion *et al,* 2004; AMREF, 2004). This is partly attributable t prevailing high levels of poverty leading to the inability of households to cop with the effects of the epidemic and over-reliance on external social suppor structures.

Finally, the assessment found that poor people in Kenya are most affecte by HIV and AIDS. They are more vulnerable to other issues such as traditiona and cultural practices, gender inequalities, violation of human and legal right and high-risk sexual practices that perpetuate the spread of HIV and worse its impact (AMREF, 2004). Subsets of the population that are more vulnerabl to infection and severe negative social impact if infected or affected includ widows, orphans, sex workers, men who have sex with men, adolescent and the youth, people with disabilities, and mobile populations such as lon distance truck drivers and fisher folk. For example, the assessment by AMRE (2005) revealed that 50% of widows undergo sexual cleansing, a high risk sexua practice in western Kenya. Much remains to be done to reach these groups wit interventions that go beyond awareness creation to addressing the myriad c cross-cutting issues that hinder behaviour change and limit their quality of life

4.2.1 | PAST EXPERIENCES IN HIV/AIDS PROGRAMMING

Many of the HIV/AIDS initiatives in sub-Saharan Africa have highlighted the feasibility of holistic HIV/AIDS responses and the value of linkages between beneficiary structures and the formal health systems. For example, the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) in Kenya which began in 2001 has shown that a comprehensive approach to care and treatment that takes cognisance of the nutritional, psychosocial, and other needs of those infected and affected is feasible in resource-poor settings (AMREF, 2006). The programme reaches tens of thousands of PLHIV with treatment, care, support, and socio-economic impact mitigation interventions in Kenya. It has established and maintained strong linkages between community support structures for PLHIV and health facilities for purposes of patient monitoring and referral. Similarly, the Kitovu Mobile AIDS Homecare Programme in Uganda implemented since 1987 has shown that linkages between communities and health systems are essential for successful implementation of home and community-based care programmes with such linkages enabling transfer of skills and effective referral *(Ibid)*.

Other projects such as the Kisumu Urban Apostolate Programme in Kenya have also highlighted the value of ensuring that a strong referral system is an integral part of community HIV/AIDS response. A traditional healer's project implemented by AMREF in Standerton, South Africa has shown that it is possible to develop strong and sustainable linkages between formal health systems and traditional healers. The project has helped traditional healers get organised with effective governance. It has enabled previously hard-to-reach populations to access counselling and testing services, behaviour change communication, and home and community-based care for those infected with HIV and tuberculosis (AMREF, 2006). The project has highlighted the challenge of providing financial incentives to community-based care providers, a policy level debate that has remained unresolved in several African countries.

Previous projects have demonstrated that it is possible for poor and marginalised communities to play a key role in an HIV/AIDS response. For instance, the Kisumu Urban Apostolate Programme trains and supports home and community-based care workers to visit and provide care to PLHIV in poor parts of Kisumu city in Nyanza province, while also mobilising, organising, and training communities to provide care and support services for themselves (AMREF, 2006). In addition, the Luwero Orphans and Vulnerable Children Support Project in Luwero district of Uganda demonstrated that it is possible to strengthen the capacity

of communities to take care of orphans, thus helping them to realise thei full potential. The project has since 2001 reached 1,800 orphans with forma education, vocational skills, and legal support on an annual budget of USD 220,000 *(Ibid)*. In the process of supporting income-generating initiative the project has shown that loan-based income-generating schemes for poo families caring for large numbers of orphans is often difficult to sustain.

Earlier work has emphasized the vital role of involving beneficiaries in desig and implementation of interventions targeting them. For instance, th Zanokhanyo Youth Centre in Peddie, South Africa has been operational sinc 2001 and has shown that youth-friendly sexual and reproductive health service provided by youths are more attractive than similar services provided by les youthful health care workers. The centre provides young people with sexua and reproductive health information, life skills training, and peer educatio It is led by a steering committee whose membership includes peer educator and youth representatives (AMREF, 2006). Similarly the International Centre fo Reproductive Health in Mombasa, Kenya has successfully reached female se workers with preventive interventions by engaging and training them as pee educators *(Ibid)*. But the same project has also shown that negotiating power among female sex workers remains low in the context of transactional sex seriously increasing the risk of HIV infection to themselves and their clients.

It has been established that the spread of the virus is fuelled by poverty precarious health conditions, illiteracy, the inferior social status of women, as we as other socio-cultural, structural and environmental factors (Ricardo, 1997a Although such cross-cutting issues continue to worsen the spread of HIV an impact of AIDS, previous work has revealed that it is possible to address thes issues. For example, the Comprehensive Community-Based Rehabilitation i Tanzania Legal Aid Services in Dar es Salaam has helped widows and orphan to safeguard their rights and social security. Their interventions have include provision of legal representation and educating society on legal and huma rights. Similar observations have also been made by AIDSCAP and Family Healt International in HIV/AIDS prevention and control projects implemented in Lati America and Caribbean Countries (Ricardo, 1997b). In Kenya, the pioneerin work of POLICY Project and Kenya National Commission on Human Right based on the realisation of the continuing trend of violation of women's right t property ownership and inheritance rights in the face of HIV and AIDS continu to register encouraging results. This initiative works with the custodians culture to address women's property ownership and inheritance rights amon communities living in the Lake Victoria Region (Nyongo, 2005).

Elsewhere, the United Nations Population Fund (UNFPA) has reported that when culture is considered in the design of a reproductive health intervention, significant success can be realised (UNFPA, 2008). This is because culture conditions people's perception and behaviour which are both central to the way HIV prevention and treatment efforts are perceived. Indeed, stigma and discrimination are both rooted in culture and tradition and worsen after HIV infection. Interventions that respect, protect and fulfil human rights in the context of HIV and AIDS are not only consistent with emerging good practice but also likely to register wider community participation and ownership (Peterson, 2004). Participation and involvement of the most-at-risk populations form the core of Maanisha response.

While the previous programming experiences described in this section highlight a number of best practices worth incorporating into HIV/AIDS programming, they do leave several issues unresolved. First, they do not demonstrate successful approaches for building on the work of pre-existing CSOs and PSOs that provide care to a considerable proportion of the population and form the bedrock for community level sustainability. Leveraging civil society energies in the HIV/AIDS response is a potentially powerful approach considering the sheer durability of CSOs. While there have been past attempts at providing grants and building the capacities of the organisations, successful experiences at combining comprehensive capacity building and provision of grants to CSOs and PSOs into one coherent and effective process remain scarce.

Second, past experiences have failed to demonstrate effective mechanisms for superimposing co-ordination and harmonisation mechanisms into prevention, treatment, care, and support interventions. Fostering better co-ordination has the potential to optimise benefits from other interventions by creating local support networks among stakeholders, reducing duplication, and enhancing shared learning of best practices.

Third, despite the significant role played by cross-cutting issues in worsening the spread and impact of HIV, past experiences on how to comprehensively mainstream the issues remain scarce with most efforts being piecemeal. Fourth, past experiences have largely focused on technology transfer with transient attempts at strengthening organisations, a situation that has hampered the utility of transferred technology and grossly limited the effectiveness of aid. Moreover, there are no past experiences that show how a programme can combine capacity building of CSOs, comprehensive mainstreaming of crosscutting issues, strengthening of co-ordination mechanisms, improvement

in the quality of life of the infected and affected people, and policy influencing through documentation of best practices in one project. While it may be argued that combining them can be a prodigious task that could jeopardise success, it is probably one of the best approaches for fast tracking social and health development in Africa, where isolated magic bullets have failed to deliver significant gains, and are unlikely to do so in future.

4.3 | THE MAANISHA HIV/AIDS RESPONSE

Project Description

Maanisha project is a community-based HIV/AIDS programme of AMREF in Kenya. It aims at sustained reduction in the incidence of HIV, AIDS and sexually transmitted infections. Maanisha is a Swahili word which means "giving meaning to". The project aims at giving meaning to HIV/AIDS interventions in Kenya. AMREF with support from the Swedish International Development Co-operation Agency (Sida) implemented "Maanisha Phase I" in the Lake Victoria region covering Nyanza and Western Provinces from January 2004 to September 2007. Based on the successful implementation of the first phase, the programme has been scaled up to cover 82 districts in Nyanza, Western, Rift Valley and Eastern provinces.

Maanisha's conceptual framework was premised on the fact that the complexity of the HIV/AIDS epidemic requires innovative strategies that draw from state-of-the-art biomedical and public health interventions that incorporate broad-based socio-economic and cultural initiatives.

AMREF implements the project in partnership with NACC, Ministry of Health (MOH), CSOs and a few PSOs. The programme is currently funded by Sida and the UK Department for International Development (DFID). About 60% of Maanisha's budget goes to grant making targeting CSOs and PSOs. The programme focuses on addressing the needs of vulnerable categories of people, in line with the Kenya National HIV/AIDS Strategic Plan for the period 2005/2006 to 2009/2010, and on narrowing the gap between the community and the rest of the health system, in line with current National Health Sector Strategic Plan (NHSSP). Specific target groups include: PLHIV; caregivers; widows; orphans; injecting drug users; sex workers; men who have sex with men; adolescents and youth; people with disabilities and mobile populations.

The specific objectives of Maanisha are:

- To build the capacity and capabilities of CSOs and private sector organisations to design and implement quality HIV and AIDS interventions
- To promote safer sexual behaviour and practices among at risk and vulnerable groups
- To strengthen facilitation, harmonisation, and co-ordination mechanisms between CSOs and GOK structures
- To support CSOs to increase access to and improve quality of healthcare and referral services for Persons Living with HIV through increased linkages with the MOH

To develop and strengthen a knowledge base for influencing policy and adoption of best practices.

To achieve these, Maanisha has applied the following strategies:

- Development of partnerships with CSOs, private sector organisations, and local and national GOK structures for a comprehensive response to HIV/AIDS
- Capacity building of CSOs, private sector organisations, and other relevant actors
- Mainstreaming of cross-cutting issues, including stigma and discrimination gender bias, disregard for human rights, socio-cultural issues, and high-risk sexual practices
- Advocating for safe sexual practices and behaviour change
- Provision of support for community-driven initiatives through a grants scheme
- Enhancement of co-ordination and facilitation among CSOs and GOK structures
- Carrying out of operations research and knowledge management for improvement of intervention approaches and possible replication.

In order to inform the implementation strategies, the project conducted a needs assessment and a knowledge, practice and coverage baseline survey in 2004 and 2005 respectively. The needs assessment focused on: the HIV/AIDS service requirements of the communities; capacity and resource needs of CSOs for a sustained and effective response to the HIV/AIDS pandemic; and the training requirements of the providers to meet the needs of vulnerable categories of people. The knowledge, practice and coverage baseline survey provided the benchmarks for the programme.

Fig 4.1: Conceptual framework for the Maanisha Project

4.3.1 | PROJECT ACTIVITIES

Strengthening capacities of grassroots civil society and private sector organisations

In Kenya, grassroots CSOs and PSOs provide prevention, care and support interventions to a considerable proportion of the country's population. Their work has helped ensure that HIV/AIDS responses are based on actual needs of communities and households, and are accessible and acceptable. During the first two years of implementation, Maanisha has significantly strengthened the capacity of 389 CSOs and PSOs in Nyanza and Western provinces to implement effective HIV/AIDS interventions. The programme has applied a twin approach of grant making and organisational strengthening. The organisational strengthening component has been operationalised using the Organisational Development and Systems Strengthening (ODSS) approach. The approach is implemented by programme staff and Constituency AIDS Control Committees (CACCs) through one-on-one mentoring with the CSOs during which capabilities in eight areas are enhanced: leadership, governance and strategy development; financial management and budgeting; administration and human resources management; networking and advocacy; community ownership and accountability; project design and management which includes enhancing their technical skills in HIV/AIDS programming; sustainability including diversification of resource base; and knowledge management (See Figure 4.2). Maanisha has developed an ODSS manual for CSOs to serve as a guide in application of the approach.

Fig 4.2: The Organisational Development and Systems Strengthening (ODSS) capacity building framework

To enhance sustainability of the capacity building efforts, Maanisha works with the government's decentralised structures. The programme has trained district development officers (DDOs) and CACCs in ODSS. These government officials whose responsibilities include supervising the implementation of HIV/AIDS activities at the grassroots level apply the ODSS skills during quarterly supervision and mentoring visits to CSOs. In addition to enhancing their capacity to apply ODSS, the programme provides funds to the CACCs to meet transportation costs during visits to CSOs and PSOs.

The programme applies an ODSS scan tool to gauge the level of capacity of CSOs and PSOs in the aforementioned components of ODSS. Programme staff and government officials apply this tool to the CSOs and PSOs at regular intervals. The results are analysed to identify where the CSOs' and PSOs' weaknesses lie and the findings used to determine how to mentor each organisation.

Strengthening co-ordination and harmonisation between government structures and CSOs

Through Maanisha project, AMREF has supported NACC to operationalise the 'Three Ones Principle' in Kenya with considerable improvement in co-ordination and harmonisation of HIV/AIDS programming at the local level. In contributing to an agreed HIV/AIDS action framework, Maanisha has strengthened more than 20 co-ordination fora in Nyanza and Western provinces including district health stakeholders' fora, annual district and provincial joint AIDS review fora led by NACC, grant makers co-ordination fora, a provincial behaviour change and communication consortium, district home and community-based care co-ordination fora, and annual operational planning led by the Ministry of Health. AMREF's support has included provision of funds, technical advice during consultation with government officials, and advocating for greater involvement of CSOs and PSOs in the co-ordination fora. The latter contributed to bridging the gap between the community and the rest of the health system which is also well articulated in the community strategy currently being implemented by the Ministry of Health and other stakeholders in health. Through these fora NACC has rallied stakeholders to undertake programming in line with the national HIV/AIDS strategy while fostering greater synergy and sharing of lessons learnt.

In an effort to enable CSOs recognise NACC as the national co-ordinating agency, AMREF has strengthened the capacity and leadership role of decentralised NACC structures at district and constituency levels to enable them fulfil their mandate. The programme has enhanced the capacity of 56 CACCs and 20 DTCs to confidently and effectively provide support to CSOs and PSOs leading to

vibrant relationships between the two levels of players. Initially, the relationship between CSOs/PSOs and CACCs/DTCs was characterised by mistrust. Further, by actively partnering and working with decentralised NACC structures, AMREF has promoted their visibility and recognition by other stakeholders. The project has further strengthened the capacity of CSOs and PSOs to design and implement programmes in line with the national strategy and policies by training them on specific thematic areas of prevention, treatment, care, support and mitigation. Key trainings have focused on behaviour change and communication, counselling and testing, and home and community-based care.

Finally, in order to help achieve the third "Three Ones" principle, on an agreed monitoring and evaluation framework, AMREF, by strengthening the capacity and authority of decentralised NACC structures, has enhanced their ability to foster application of the co-ordination fora and supervisory visits to CSOs and PSOs. The project has also trained CSOs and PSOs on how to report to NACC using the standard community organisation project-based AIDS reporting forms.

Grants scheme

In order to address the lack of resources, Maanisha has implemented a grant scheme for CSOs and PSOs. The scheme is closely linked to the capacity building component to ensure that supported organisations have the necessary management and technical capacity to utilise the resources and implement effective HIV/AIDS interventions. The scheme consists of the following key elements: demand creation; grants provision; capacity assessment; financial management and systems strengthening; and financial mentoring and monitoring.

Demand creation

In implementing the grant scheme, Maanisha has applied a hybrid approach of 'call for applications' and 'proactive approach'. In the 'call for applications' approach, the programme creates demand among CSOs and PSOs who then submit applications. Demand creation entails working closely with the NACC and Ministry of Health structures at district level to organise dissemination fora for sensitisation and call for applications. Through this approach, the CSOs and PSOs propose need-driven interventions by responding to the call. Before funds are released, a discussion with the eligible CSOs and PSOs is undertaken to help focus the interventions to the Maanisha and Kenya's HIV/AIDS strategy. In the

'proactive approach', the programme actively seeks groups targeting most-at-risk populations.

Grants provision

The project manages the grants through a transparent mechanism involving independent external grant review committees. The implementation team receives, records, and undertakes preliminary review and initial assessment of submitted applications. The team then submits its recommendations to the regional technical review committee. The technical review committee in turn makes recommendations to a national grants approval committee for approval to allow for disbursement of grants to qualifying organisations. The assessment of applications is based on criteria developed and approved by AMREF. The size of the grant per organisation ranges from USD 7,000 to USD 20,000 per year.

Capacity assessment

To effectively manage risk, Maanisha carries out capacity assessment for all prospective CSOs and PSOs before funds are released. Among others, the capacity assessment process checks whether the organisations being funded have a strong grassroots presence and governance structures sufficient to implement the proposed interventions.

Financial management and systems strengthening

As soon as the review process and capacity assessment are finalised, selected CSOs and PSOs are taken through a three-day training to enhance their skills and commitment to the goals and objectives of Maanisha programme and enable them understand the financial management procedures as well as reporting requirements. National guidelines on specific technical areas are provided during the workshop. At the end of the training, the CSOs and PSOs sign contracts and receive their cheques.

Financial mentoring and monitoring

Maanisha programme implementation team provides continuous mentoring and monitoring to CSOs and PSOs during quarterly and ad hoc visits to foster compliance with contractual obligations, utilisation of funds as per approved budget and work plan, and proper maintenance of records. During the first two years of implementation, programme staff have mentored initially weak CSOs and PSOs and witnessed dramatic improvements in financial management capacity and performance. During the visits and review of reports, CSOs and PSOs with persistent challenges in financial management, record keeping, and

documentation are identified and taken through detailed training to enhance their skills and strengthen organisation systems. To guide strengthening of capacity of CSOs and PSOs in financial management, Maanisha has developed and applied a simplified financial management model named the *pot model*

The Pot Model

Maanisha applies a simplified financial system called the 'pot model'. This is a financial management model for lay populations. Key facets of the pot model are financial planning, recording, and reporting. The name of the model is derived from a common household kitchenware used by local communities. The concept of the pot model is based on the financial management principles of accountability, transparency and stewardship. There are two pots that are used in the model. One pot is labelled "Bank" and the other "Cash". "Bank" pot is also called the big pot whereas the "Cash" pot is also known as the small pot. The model demonstrates the figurative flow of funds from outside (donor) into the big pot, and from the big pot into the small pot. The model is made even more user-friendly by a simplified cash analysis book that highlights the place of both big and small pots.

Benefits of the Pot Model

- Financial record keeping (book keeping) is easily done and the records are clear and accessible to the community.
- The model is an excellent tool for financial planning. CSOs are able to undertake accurate financial planning and budgeting.
- Organisations applying the pot model demonstrate excellent financial reporting in terms of timeliness and quality.
- Financial reports perception changes from donor-driven reports to a report for CSO members that is a yardstick for implementation of activities.
- Stakeholders have shown considerable confidence in CSOs supported by Maanisha because of good accountability and transparent practices. This has created visibility for the CSOs and resulted in their involvement in HIV/AIDS stakeholders' fora.
- The model is also contributing to sustainability. CSOs no longer have to pay a book keeper. More importantly, CSOs that have implemented the pot model have transferred the financial management skills to other grass roots groups, creating a replication effect. They are also able to access funding from other organisations due to good accountability and transparency practices.

Behaviour change communication: mainstreaming cross-cutting issues

The Maanisha behaviour change communication strategy aims at adoption of positive sexual behaviour and practices. In implementing the strategy, AMREF recognizes that for individuals to reduce their level of risk or change their behaviour, they first need to understand the basic facts about HIV/AIDS, learn a set of necessary skills, and have access to appropriate services and tools such as counselling, testing and condoms. AMREF also recognizes that individuals are part of the wider community and are influenced by it. Thus, Maanisha's behaviour change and communication strategy involves an integrated and interactive process with communities aimed at developing tailored messages and approaches using diverse communication channels.

Maanisha has stimulated dialogue to broaden the scope of minimising sexual health risks and promoting issues of treatment, care and support to people infected and affected by HIV/AIDS. Following its mid-term evaluation in 2006, the programme has intensified advocacy for safer sexual and reproductive health behaviour with increased focus on the most-at-risk populations (MARPs) including youth, widows, sex workers, men who have sex with men, as well as on the special groups including discordant couples, PLHIV and people with disabilities. The programme in partnership with selected CSOs develops region-specific and appropriate behaviour change and communication approaches and messages for MARPs and other vulnerable populations.

Behaviour change communication approaches are linked to advocacy and mainstreaming of cross-cutting issues, which is a critical aspect of an effective HIV/AIDS response. In Maanisha, advocacy is a process of influencing decision makers and public perceptions about an issue of concern, and mobilising community action to achieve change in among others customary, legislative and policy aspects to address the concern. Like advocacy, the process of mainstreaming cross-cutting issues aims to create an enabling environment for sexual and social behaviour change. The enabling environment is perceived as one where customs, traditions, laws and public policy protect and promote the rights of MARPs and vulnerable groups, support effective programmes, reduce vulnerability to sexually transmitted infections and HIV, and address the consequences of infection. To operationalise these ideals, the programme has developed partnerships with CSOs and PSOs, the custodians of culture and community leaders, including councils of elders and regional networks. For example, the programme has worked with Women Action Forum for Networking that has engaged communities in Nyanza province in HIV/AIDS

education through gender and human rights perspectives (WAFNET, 2007). Similarly, partnership with the Luhya Elders Forum and the Teso Council of Elders has enabled the programme to address women and children property ownership and inheritance rights.

Care and support

Maanisha has helped bridge gaps that exist in the continuum of care and support from the formal health system to the community and vice versa by supporting both levels of care. The programme facilitates meetings between MOH officials and CSOs/PSOs aimed at identifying mechanisms to close existing gaps. For example, in one of the provinces, Maanisha is piloting a community network aimed at bridging the gap between CSOs and local health facilities. The programme has enabled funded CSOs and PSOs to form and develop linkages with support groups where PLHIV go for psychosocial and spiritual support. These support groups are an important part of strengthening the referral system. For example, many of them are today recognised by comprehensive care centres (CCCs) at local health facilities.

Maanisha distributes a community referral tool developed by the Ministry of Health to support groups. In addition, as part of strengthening the referral system, CSOs and PSOs support transportation of clients in need of medical attention to local health facilities.

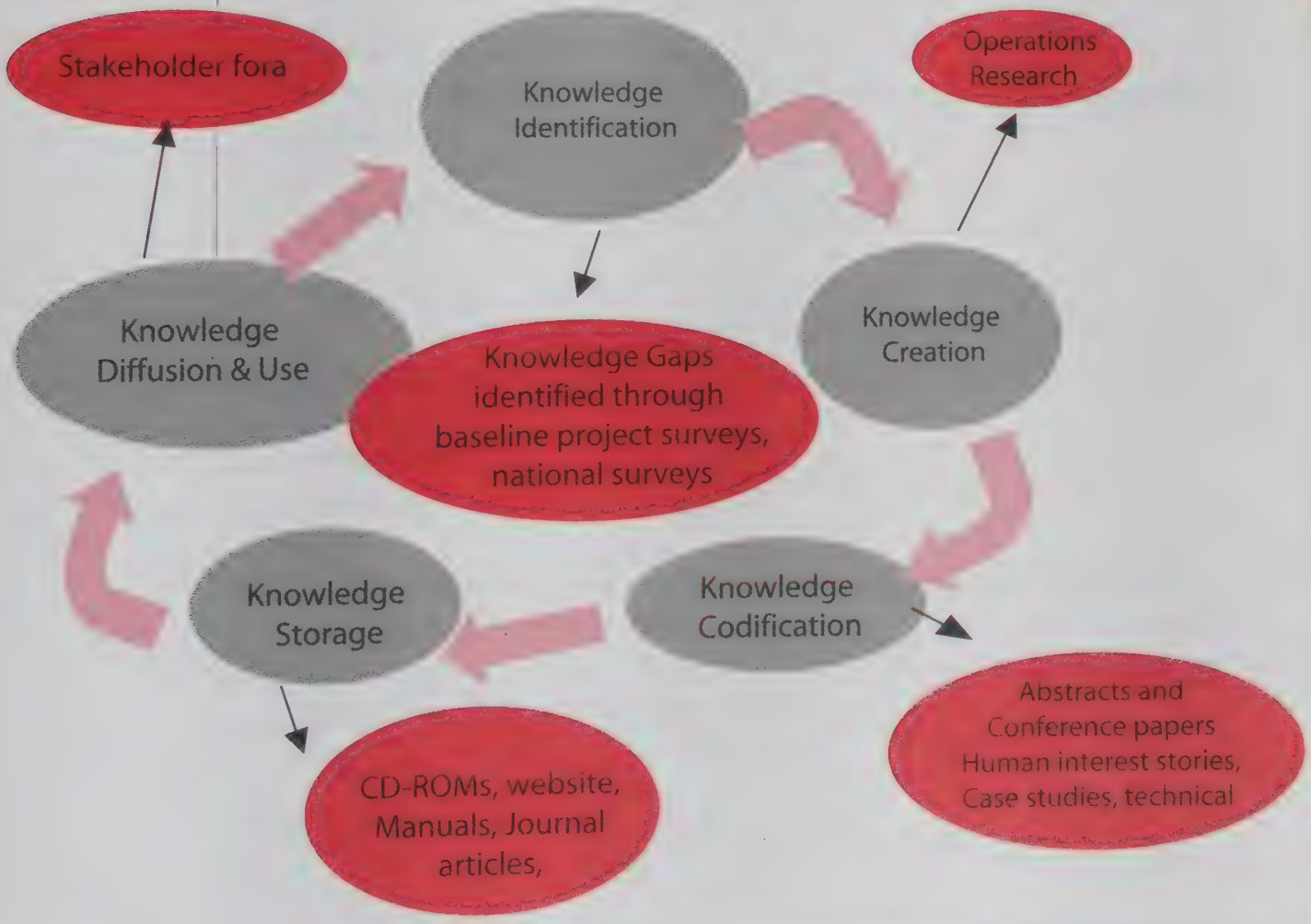
The programme enhances the capacity of communities to provide care and support by funding CSOs and PSOs engaged in provision of home and community-based care, care and support for orphans and vulnerable children, PLHIV and widows. In addition to providing direct care to beneficiaries, these organisations also use some of the funds to train home and community-based caregivers and counsellors to provide services to PLHIV, youth, and other categories of most-at-risk populations and special groups. In Kenya, provision of home and community-based care includes basic clinical care, basic palliative care, nutritional counselling and education, and psychological and emotional support to PLHIV and their families. The funded groups also procure home and community-based care kits and distribute them to caregivers. The programme also funds organisations that provide nutritional support to PLHIV; these organisations offer sustainable means of nutritional support such as seeds for planting to beneficiaries and organise linkages with Agricultural Extension Officers (AEOs). Other funded CSOs support orphans and vulnerable children to access formal education, food and nutrition, medical care and psychosocial support.

Maanisha has supported provision of quality assured services to beneficiaries by encouraging formal health care workers to provide supportive supervision to CSOs and by ensuring that CSOs' and PSOs' trainings are facilitated by MOH personnel. To this end, the programme links the organisations with ministry officials especially district HIV/AIDS co-ordinators and district home and community-based care co-ordinators. Further, the programme facilitates provision of CSOs and PSOs with government approved home and community-based care guidelines, diaries, tally sheets, notebooks, referral forms and other relevant information, education and communication materials, as a means of aligning their activities to the national HIV/AIDS strategy.

Knowledge Management

The programme has identified lessons and best practices for policy influence and practice to inform future HIV/AIDS programming, especially in resource-constrained settings. Key best practices include linkage mechanisms between health facilities and local communities, the ODSS approach to capacity building,

Fig 4.3: Maanisha's knowledge management framework



the Pot Model, approaches for mainstreaming cross-cutting issues, approach to grant making, and Maanisha as a comprehensive HIV and AIDS response model. Knowledge management within Maanisha programme also entails working with CSOs/PSOs and government structures to identify knowledge gaps and finding ways of addressing them, for instance, by undertaking operations research.

In knowledge management, Maanisha has formulated a strategy to guide the processes of knowledge identification, knowledge creation as well as knowledge dissemination in the various national and international fora (Figure 4.3). In addition, Maanisha has generated several knowledge products.

4.3.3 | ACHIEVEMENTS

By June 2008, Maanisha programme had provided grants amounting to USD 4.98 million and strengthened organisational systems and technical capacity for 389 CSOs and PSOs enabling them to design and implement effective HIV/AIDS interventions. Further, the programme strengthened the capacity of 56 CACCs and 20 DTCs to support the CSOs. Based on a mid-term evaluation undertaken by AMREF in 2007, funded organisations demonstrated considerably enhanced capacities including the following: improved governance with all of them having elected leaders and 93% having a constitution; 91% use finances efficiently; all of them provide services in line with national guidelines; and all work with an annual plan.

Qualitative and quantitative data reveal that the Pot Model and ODSS approaches are effective tools for strengthening the organisational capacities of CSOs and PSOs. For example, during the mid-term evaluation, an official of a CSO said the following regarding the Pot Model,

"We demonstrated good financial management through proper book keeping, quality financial reports and involvement of the community in financial matters. This led to additional funding from a new donor, thanks to the Pot Model of financial management"

Thomas Oluoch, Programme Manager,
Women in Fishing Industry Programme for Education and Development in Bondo District.

Similarly, a CACC had this to say regarding ODSS,

"Even if Maanisha was to end now, one thing that the project will be remembered for is the ODSS tool. It has given us a framework that enables us to assess CSOs in a standardised manner and plan with them on how to improve. Previously, we had nothing. Everyone worked on their own",

CACC,
Nyanza Province.

In 2006, a quasi-experimental pre and post intervention assessment on four components of ODSS revealed that application of ODSS as an intervention leads to significant improvement in the capacities of CSOs' institutional processes and systems and technical capacity (Table 4.1).

Table 4.1: Effect of ODSS model on capacity of CSOs and PSOs

Component of ODSS	Sub-component assessed	Comparison group (n=117)		(Intervention group (n= 117)	
		Before (%)	After (%)	Before (%)	After (%)
Leadership and governance	Transparency and accountability	50%	56%	50%	93%
	Regular meetings	33%	27%	33%	93%
Technical capacity	Gender mainstreaming	19%	22%	26%	50%
	Use of national guidelines	13%	14%	14%	50%
Project design and management	Activity development planning 37%	38%	37%	78%	M & E
	procedures	33%	31%	33%	74%
Sustainability	Efforts towards sustainability	23%	23%	22%	29%
	Resource base diversification	21%	21%	21%	24%

(Source: http://www.amref.org/search/poster/)

A client satisfaction survey undertaken in 2007 revealed that majority of CSOs and PSOs (82%) rated ODSS as implemented by Maanisha to be of good to excellent quality (Source: http://www.amref.org/search/poster/). About three-quarters (76%) regarded lead time to receiving grants as adequate.

Through support provided to CSOs and PSOs and enhanced co-ordination of the HIV/AIDS response, the programme has reached and improved the quality of life of 61,335 PLHIV. It has supported 184 CSOs to implement home and community-based care initiatives, distributed 1,796 home and community-based care kits, and trained 4,300 home-based care givers and 330 peer counsellors to provide care to MARPs. The programme has reached and enhanced the quality of life for 43,122 orphans and vulnerable children.

Further, the programme has reached over 400,000 people with social and behaviour change messages through funded CSOs and PSOs. It has distributed more than a million condoms, including 25,000 female condoms. Further, it has strengthened 10 voluntary and counselling centres that have provided services to more than 26,250 clients including those with disabilities.

Maanisha has supported two networks and 328 CSOs to mainstream cross-cutting issues, especially addressing human and legal rights violations, gender inequalities, and socio-cultural issues. As a result of the programme's efforts, many PLHIV, especially women, have reported recovering property they had lost through disinheritance following the deaths of their spouses. Further, the proportion of widows undergoing sexual cleansing fell from 50% in 2005 to 40% in 2007.

Maanisha has strengthened co-ordination and harmonisation of HIV/AIDS response in Nyanza and Western provinces. Today, most stakeholders in the two provinces acknowledge the leadership role of NACC and implement interventions in line with the national guidelines. Notably, anecdotal evidence indicates that the relationship between NACC and CSOs/PSOs is vibrant.

The programme has also made significant progress in terms of sharing lessons and best practices, both locally and internationally. For instance, Maanisha demonstrated how the ODSS approach has been applied to enhance the CSOs' organisational capacities for effective HIV/AIDS programming at the international AIDS Society Conference 2007 in Mexico and later at the International Conference on AIDS and STIs in Dakar, Senegal shared how the global principles on aid effectiveness can be unpacked and applied at the community grassroots level for effective HIV/AIDS response in resource-constrained settings.

4.3.4 | KEY LESSONS LEARNT

The implementation of Maanisha project has brought to the fore several key lessons of value for future HIV/AIDS programming. First, the project has proved that exposing grassroot CSOs to national strategies and standards improves the quality of activities implemented. For this to work there needs to be an effective monitoring and mentoring mechanism that requires adequate programme staff. Second, involvement of government structures in co-ordination of HIV/AIDS efforts and training and mentoring CSOs and PSOs significantly improves the relationship between the two players, enhances sustainability of capacity building efforts, and results in good community response and better co-ordination of interventions. Project experiences have shown that for this to work, government structures need to be supported with capacity enhancement and transportation when visiting CSOs.

Third, grant making to CSOs and PSOs should include a comprehensive capacity building programme to enhance quality of interventions. It should cover capacity assessment prior to disbursement to reduce risk and inform the capacity building process for each CSO and PSO. Further, the following considerations can significantly enhance a grants scheme: involving external oversight committees in reviewing grants applications and processes allows for objectivity, alignment with key programme priorities, and ownership and support from local stakeholders; a 'call for applications' approach is a good way to roll out a grants programme but repeat grants should include a proactive approach to ensure that most-at-risk populations are not left out. It is necessary to have a co-ordination mechanism for sharing information on potential grantees between grant making organisations – this ensures maximisation of resources and non-duplication of efforts.

The mainstreaming of cross-cutting issues within the overall programme framework is an effective way of fostering community behaviour change. Finally, a systematic framework of identification of knowledge gaps in HIV programming, and creation and dissemination of knowledge products serves to promote meaningful replication of the best practices by stakeholders.

4.4 | CONCLUSION

As the HIV/AIDS pandemic continues to ravage Africa, more concerted effort by all stakeholders with the leadership of governments is needed. Key gaps that effective national and regional responses must surmount include poor co-ordination, lack of capacity among the communities, inadequate participation of communities in HIV/AIDS mitigation, limited availability of resources to communities, and challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most-at-risk populations.

There is a lot that new HIV/AIDS programmes could learn and possibly replicate from previous experiences. Governments need to seek new ways of genuinely engaging with and leveraging the work of civil society and the private sector, considering that in many African nations the latter two players provide health care services to more than half the population. Furthermore, governments also need to persistently enhance co-ordination of the HIV/AIDS response by providing credible leadership to multiple stakeholders.

Effective responses must go beyond traditional prevention programming approaches that have not shown optimal benefits; they need to address a myriad of structural issues that are country- and regional-specific, and that fuel the spread of HIV and worsen its impact. Key issues that every programme will need to address include human and legal rights violations, gender inequalities, and prevalent socio-cultural issues. Africa needs to fast track the shift from over-reliance on technology transfer to a balance between technology, local innovation, and enhancement of leadership and organisational capacities at all levels of HIV/AIDS programming. Although holistic programming that addresses all key drivers of HIV infection and impact is never easy for programme managers, it is the way to go if more of Africa's nations are to effectively address HIV/AIDS. There is need to enhance sharing of information and lessons regarding emerging best practices for comprehensive programming and approaches to addressing difficult issues for possible replication.

Maanisha is an evidence-based model of comprehensive HIV/AIDS programming that is replicable in resource-poor settings. The model has brought to the fore key programming practices that have the potential to enhance the effectiveness of a national or local response. It has made considerable achievements by combining a number of HIV/AIDS programming aspects into one initiative. First and foremost, the model brings on board the aspect of strengthening capacities of grassroots CSOs and PSOs though creative adaptation of the ODSS approach. Second, is the aspect of moulding creative partnerships with decentralised NACC and MOH structures complemented with a 'we will walk together'

programming mentality when dealing with grassroots organisations. Third, the model aspect of providing resources through a grants scheme that is enhanced by use of financial management models that are user-friendly for lay populations, seamless integration with capacity building efforts, application of approaches to reach MARPs and involvement of external and independent oversight committees to oversee the process. Fourth, is the aspect of strengthening co-ordination and harmonisation between government structures and CSOs/PSOs; innovative and structural approach to behaviour change; care and support interventions that build on the rights-based approach, especially participation and involvement of beneficiaries. Finally, the model mainstreams the aspect of knowledge management in working with stakeholders in the identification, documentation, sharing and replication of success stories and best practices in HIV/AIDS programming.

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Vision

Better Health for Africa

Mission

AMREF is committed to improving health and health care in Africa. We aim to ensure that every African can enjoy the right to good health by helping to create vibrant networks of informed and empowered communities and health care providers working together in strong health systems.

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